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ESSENTIAL HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

REVIEWING ACCESS TO MINIMUM ESSENTIAL HEALTH CARE

MAY 19, 1987

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ESSENTIAL HEALTH CARE

TUESDAY, MAY 19, 1987

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The Committee met, pursuant to notice, at 10:22 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (Chairman of the Committee) presiding.

Present: Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The Committee will come to order.

Today we are introducing legislation to bring health care within reach of every working family in America.

The individuals gathered here today—and the groups they represent—share a common commitment and a common sense of urgency.

There is a fundamental flaw in a health care system that denies millions of Americans the right to health care that is adequate for their needs and affordable for their pocket-books.

According to the Census Bureau, thirty-seven million men, women and children have no health insurance at all. Seventeen million more have health insurance that even the Reagan Administration admits is inadequate. Since 1980, the number of uninsured Americans has risen by more than a million citizens a year. Day in and day out across the country, Americans are denied health care because they cannot pay, and countless more do not even seek the care they need because they know they cannot affort it.

The lack of access to health care has predictable consequences in human terms. Every American without health insurance is an American tragedy waiting to happen—and it can strike anyone at any age in any community.

Infants will die at birth or suffer lifetimes of pain and disability, because their mothers did not receive prenatal health care. The United States is first in the world in wealth, first in military power—and sixteenth in infant mortality. No baby in America should die because a mother was forced to choose between a visit to the doctor and food on the table.

The vast majority of uninsured Americans—about 70 per cent—are workers or their dependents. Most work hard—forty hours or more a week, fifty-two weeks a year—and they deserve access to essential health care.

The proposal we are introducing today will require that every working American have access to at least a minimum package of

health insurance. Employers have been required since 1938 to pay a minimum wage—and in 1987 it is time to insist that they provide minimum health insurance, too.

A minumum benefit package does not mean Cadillac plans or first dollar coverage of health expenses. It does not include many desirable benefits. But it does mean basic protection against the financial burden of major illness.

First, it covers all medically necessary hospital care, physician care, diagnostic tests, and prenatal and well-baby care.

Second, it provides catastrophic protection against serious illness, with a cut-off of $3,000 in out-of-pocket expenses.

Third, it limits deductibles to $250 a person and $500 a family, and it limits co-payments to 20 per cent of the cost of any service.

Fourth, it limits the worker's share of the premium to 20 per cent of the cost.

Fifth, it offers employers the opportunity to modify the coverage to meet special needs of their employees, so long as the overall value of the plan is not cut back.

As I talk to groups around the country about this program, two concerns appear again and again. People are worried about America's competitiveness in the world economy, and they are worried about the impact on small business.

I believe this plan will help, not hurt, American business in the struggle to compete in world markets. Seventy per cent of all uninsured workers are employed in businesses that are not substantially involved in foreign trade. The firms at the cutting edge of international competition insure their workers—and they are paying too much today because other firms pay too little.

There is no free lunch in health care or health insurance. When hospitals provide charity care for someone who cannot pay, that care is hardly free. It is paid for in the form of higher health care charges to paying patients and higher premiums to firms that provide insurance. Joseph Califano, the former Secretary of Health, Education and Welfare, and now in charge of containing health care costs for Chrysler Corporation, testified before the Labor and Human Resources Committee in Janaury that a minimum health care bill would improve American competitiveness by taking the nation's charity care burden off of the balance sheets of our internationally competitive businesses.

It is time to put these costs back where they belong—on the firms that refuse to protect their workers' health. If we succeed in this endeavor, the country as a whole will be the winner, because a healthier America will also be a more competitive America.

Similarly, most small businesses already insure their workers. Even in firms with less than 25 employees, almost 60 per cent of the workers are employed by companies that offer health insurance.

It is true that the smallest firms have the largest problems in providing health insurance. Typically, their costs for such insurance are excessive; often they cannot purchase adequate insurance for all their workers at any price; and often they do not qualify for the tax breaks available to larger firms.

The plan we are offering today addresses these problems and establishes a program that small businesses can live with—and pros-

per under. It offers economies of scale and other incentives to reduce the average cost of insurance to small business by 30 per cent compared to the current system.

It is also important to put the cost of this coverage in perspective. The package this bill provides would cost about 10 per cent of what an employer is required to provide under the minimum wage. Past minimum wage increases far in excess of 10 per cent have produced no significant unemployment increase. In 1949, the minimum wage was increased by 87 per cent, but unemployment fell. In 1955, the minimum wage was increased by 33 per cent, and unemployment fell. In 1961, the minimum wage was increased by 15 per cent, and unemployment fell. The Minimum Wage Study Commission completed a $17 million study of the effects of the minimum wage in 1981, and concluded that the unemployment effects of the minimum wage are negligible. The old charge that providing decent compensation to workers will lead to unemployment is tried and false.

As against these specious risks, compare the certain result of this plan—it will provide decent coverage, better health care, protection against financial hardship and peace of mind for tens of millions of Americans.

In addition, our proposal contains two other special features for small business:

Businesses less than two years old with less than ten employees will be permitted to provide only the catastrophic protection for their workers.

Companion legislation will reform the unfair tax treatment of small businesses so that they are placed on an equal footing with larger corporations in providing health insurance.

We estimate that employers subject to this legislation will be able to purchase this health insurance package at a cost of approximately 40 cents an hour for each employee. But for the majority of small businesses that now offer an insurance plan, the cost will actually drop.

This is not a complicated plan. It creates no burdensome regulations. It requires no massive government bureaucracy. It is not back-door national health insurance. It simply extends the current system of employment-based private health insurance to millions of families that are now unfairly denied participation. Unless ideology dominates debate, there is no good reason why the federal government should not facilitate access to health insurance by legislation such as this.

The hospital and labor representatives here with us today clearly understand that this idea can work, and can make a difference in the lives of millions of workers and their families. And when the dust of the battle has cleared, I think we will not only have a bill, but have a bill that the vest majority of businesses, large and small, can live with too.

We will ask Jackie Davison, Helen Lipowsky, and Nina Pettiford if they would be kind enough to come up, please.

I have a statement here from my friend and colleague from Illinois, Senator Simon, and we will make that a part of the record at the point.

[The prepared statement of Senator Simon follows:]

PAUL SIMON
ILLINOIS

COMMITTEES
LABOR AND HUMAN RESOURCES
JUDICIARY
FOREIGN RELATIONS
BUDGET

United States Senate
WASHINGTON, DC 20510

STATEMENT OF

SENATOR PAUL SIMON

May 19, 1987

Senate Committee on Labor and Human Resources

Mr. Chairman:

Thank you for your fine work and leadership in this area.

I am particularly glad to see Helen Lipowsky from Danville, Illinois here today. Her story is a tragic one and I know that she comes here to testify before the Committee under very difficult circumstances. She is to be commended for her courage under such hardship.

As you know, she is one of some 35 million Americans who are either uninsured or underinsured. By my figures that is about one in every six Americans. One million are refused medical care annually because they cannot pay and another 4 million don't seek care because they can't pay.

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This is one tragedy of a nation that has not made a priority of health care and frankly there is no good excuse for it. Helen Lipowsky is an outstanding example of a hard working person who is struggling to support a family. Why shouldn't Helen Lipowsky and her children be able to received needed medical care without the fear of losing their home? There is no good answer.

In meetings with private employers and insurance companies, I have been urged to leave well enough alone. I have been told that legislation that would encourage minimum essential benefits would break the backs of small business in America.

I do not believe any of us on this Committee seeks to do that. The small employer serves a vital role in the U.S. economy and the concerns of the small businesspersons cannot be overlooked in legislative proposals.

More recently I have been told, "Don't legislate these benefits. They are unnecessary." Or I hear, "The private sector is taking care of it."

Mr. Chairman and my colleagues on the Committee, I simply wish that this were the case. But I have learned in this great free enterprise system that while there are people standing in line

to apply for jobs and there are people standing in line to received federal help, there are not people standing in line to help those among us who cannot help themselves. And there are precious few people waiting to serve those who cannot afford to pay for services.

The witnesses here today will tell the stories of unmet needs and difficult decisions. I thank them for bringing their personal accounts to our attention. And I again thank the distinguished Chairman for his efforts in addressing their needs.

I ask unanimous consent that this statement be inserted into the Committee Record as if spoken.

The CHAIRMAN. We will ask all of our guests if they would be kind enough to take their seats, as we want to give the witnesses our attention. We ask everyone if they would be good enough now to take their seats.

We want to hear from our witnesses. We are delighted to have our guests here. We will ask them if they will refrain from speaking so we can give full, undivided attention to our witnesses now. We have to insist on quiet here this morning.

Our first witnesses this morning will set the foundation for the rest of our hearings. They are three individuals who portray and symbolize the kind of problems which confront us as a nation as we attempt to deal with the uninsured worker situation. Each of them will provide us with first-hand testimony about this subject. I welcome them to our hearings and invite them to come forward to the witness table.

They are Jackie Davison, from Ohio; Helen Lipowsky, from Illinois; and Nina Pettiford, from Pennsylvania. We want to thank all of them for appearing here today. We know it is never easy to talk about the health care needs of our families. I think we all come from a tradition where we like to keep these matters within the bosom of our family, so I want to indicate how much we appreciate the willingness of the witnesses to share their life's experience with us, because your problems are the ones we are trying to address with this legislation.

We want to find out whether there really is a need out there, and I think that you demonstrate very clearly that there is.

So we will start off with Jackie Davison. We are delighted to have you. I have a few questions here. I see some paper there in front of you, Jackie, so if you would like to, would you like to make a comment or shall I ask you some of the questions?

STATEMENT OF JACKIE DAVISON, ELYRIA, OH; HELEN LIPOWSKY, DANVILLE, IL; AND NINA PETTIFORD, PITTSBURGH, PA

Ms. DAVISON. You can ask me some questions.

The CHAIRMAN. Let me ask you just a few questions. You are the nurses' aide in a nursing home, is that right?

Ms. DAVISON. Yes.

The CHAIRMAN. Would you tell us something about the nursing home, what kind of patients are staying there and what kind of illnesses they have.

Ms. DAVISON. Well, at the nursing home that I work there are over 50 patients and we have various types of deadly diseases, and we have to take extra precautions in taking care of those.

We have Parkinson's disease, we have Alzheimer's disease, and we have also—they just placed a bulletin on the board that we are going to be taking AIDS victims, so there is the constant fear that you never know what you are dealing with constantly.

The CHAIRMAN. So the people who are staying there are quite sick, is that right?

Ms. DAVISON. Yes.

The CHAIRMAN. The reason for my asking you about these things is that your situation points up a real irony. Here we are dealing with the whole question of health insurance, trying to understand whether there is a need to do something about the problem of some businesses in our country not providing any form of health insurance to their workers; and here you are working for a nursing home, the kind of business which, more than any other, should be sensitive to the needs of sick people and how expensive it is for sick people to be taken care of, yet this nursing home itself does not help its own workers get health insurance. I suppose that thought must have crossed your mind, has it not?

Ms. DAVISON. It has, because I take care of these patients and I give it my best shot, yet they have insurance, management has insurance, and I do not have anything. I have two kids to take care of. Is that fair to me?

The CHAIRMAN. Let me ask you just a couple of questions. I think you said that you have no insurance and that your little girl needs some medical tests done, is that right?

Ms. DAVISON. Yes. Last December she developed some severe stomach pains. She was doubled over, vomiting, and I waited until the last minute to take her to the doctor because I could not afford to even take her to her own doctor, so when I did take her they told me that she had to have x-rays, blood work, urine specimen, and all these other tests, and that is $300 to $400. I do not have that kind of money and I work full-time and I still do not have that kind of money.

The CHAIRMAN. You have difficulty in paying for those tests. You said the tests were $300 to $400, is that right?

Ms. DAVISON. Yes, not including the office costs.

The CHAIRMAN. And the doctor tells you that these tests should be done?

Ms. DAVISON. Yes, she did.

The CHAIRMAN. And your daughter is suffering from stomach pains, is that right?

Ms. DAVISON. Right, and she has an allergy and that is more money out.

The CHAIRMAN. Do any of the people you are working for at the nursing home know about the problems you are having?

Ms. DAVISON. I am sure they do, because I have never called up in almost three years since I have been there, and finally I have to start calling up because my child is at home sick. But they do not even care, you know, we are workers with nothing. You know, they do not care about my situation or my circumstance as far as health insurance for me or my kid, but they have insurance, management has it, why can I not have it?

The CHAIRMAN. So, really the only time that you have taken off or have been missing in the last three years has been to look after your daughter, is that correct?

Ms. DAVISON. Yes, and I have only done that one time and that is because I need the money also.

The CHAIRMAN. We are going to put your entire statement in the record, but I think—you work how many hours a week?

Ms. DAVISON. I work a total of 8 hours a day, so that is——

The CHAIRMAN. So you are working 40 hours a week, you have been working for 3 years, you have got two children, as I understand, one for whom the doctor has told you to get these tests——

Ms. DAVISON. Yes.

The CHAIRMAN [continuing]. And you are barely able to make ends meet and you are having to defer getting those tests for your daughter.

We were asked earlier in the press conference—I think you were there, Jackie—about the costs of these. We did not get any questions from any of the members of the press about the costs in human terms. How do you put a dollar figure on the kind of anxiety that you have? I bet you worry about your daughter?

Ms. DAVISON. I do. My hair is falling out, I have lost weight. I am constantly a nervous wreck because you deal with your job mentally and physically, because we do a lot of heavy lifting, you know, and we have to put our hands in their mouths and do their teeth and things like that, they are constantly coughing on us. Okay, like staph, if I catch it at work, they will pay for it. If I take it home to my kids, they will not pay for it, and that is really a burden on me personally, with my gas and my electric and my phone. You know, I cannot even go to a movie, you know. I cannot even go out and buy a new pair of shoes or clothes because my mom has to help me with that. Here I am 30 years old and I cannot even afford to give my kids proper medical treatment. You know, that is not fair to them or me, where there are other people with medical care, they can afford it, I cannot.

The CHAIRMAN. I think you make the case very clearly, rather tragically. We will include your complete statement in the record.

[The prepared statement of Ms. Davison follows:]

TESTIMONY OF JACKIE DAVISON, NURSE AIDE
PALMCREST NURSING HOME, ELYRIA, OHIO
BEFORE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

GOOD MORNING. MY NAME IS JACKIE DAVISON. I APPRECIATE THE OPPORTUNITY TO COME HERE TODAY TO TESTIFY ON THE NEED TO EXTEND HEALTH INSURANCE TO ALL WORKING PEOPLE. I'D LIKE TO SHARE WITH YOU MY SITUATION, WHICH UNFORTUNATELY IS ONE SHARED BY MY CO-WORKERS IN OHIO.

I WORK AS A NURSE AIDE AT PALMCREST WEST NURSING HOME IN ELYRIA, OHIO. I AM ALSO A MEMBER OF THE SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 47. MY EMPLOYER DOESN'T OFFER ANY HEALTH INSURANCE. AFTER TWO AND ONE-HALF YEARS AS A NURSE AIDE, I MAKE ONLY $5.52 AN HOUR. I'M A SINGLE PARENT OF TWO CHILDREN - LE-PAUL WHO IS 11 YEARS OLD AND CHARNESHIA WHO IS 6 YEARS OLD - AND I CAN BARELY MAKE IT ON THIS INCOME. I WISH I HAD HEALTH INSURANCE; I WORK HARD AND DESERVE BETTER - SO DO MY KIDS.

THIS IS WHY I'VE TAKEN TWO DAYS OFF WORK TO COME HERE THIS MORNING FROM ELYRIA, OHIO.

I'VE NEVER HAD INSURANCE ON ANY OF MY JOBS, AND I'VE WORKED AT RESTAURANTS AND AT A DAY CARE CENTER. BUT I STILL CAN'T BELIEVE THAT A NURSING HOME -- THAT PROVIDES CARE TO THE SICK AND FRAIL ELDERLY -- DOESN'T PROVIDE HEALTH INSURANCE TO THEIR OWN WORKERS.

I STARTED OUT AS A PART-TIMER AND MEDICAL ASSISTANCE PAID FOR MY FAMILY'S MEDICAL CARE. BUT WHEN I WENT TO FULL-TIME, I LOST THAT COVERAGE. SO FOR THE PAST COUPLE OF YEARS I HAD TO GET BY ON WHAT LITTLE I MAKE, BUT I CAN NOT KEEP UP WITH THE MEDICAL BILLS I HAVE. RIGHT NOW I OWE OVER $600 AND THAT'S JUST FROM DOCTORS' VISITS AND PRESCRIPTIONS.

MY DAUGHTER IS SUSCEPTIBLE TO INFECTIONS AND GETS SICK A LOT. I TRY TO PUT OFF TAKING HER TO THE DOCTORS UNTIL THE LAST MINUTE BUT THEN I END UP PAYING MORE. LIKE THE TIME RECENTLY WHEN SHE GOT STREP THROAT. I WAITED UNTIL SHE GOT A HIGH FEVER AND THEN TOOK HER TO THE DOCTOR. THE DOCTORS' VISIT AND PRESCRIPTION COST OVER $50.

THIS APRIL, SHE WAS COMPLAINING OF SEVERE STOMACH PAINS AND THE DOCTOR TOLD ME THAT SHE SHOULD HAVE SOME TESTS DONE - YOU KNOW, URINE SPECIMENS, BLOOD WORK, X-RAYS - TO FIND OUT THE PROBLEM. I HAVEN'T DONE THEM YET BECAUSE I CAN'T AFFORD TO PAY FOR $300-$400 WORTH OF TESTS. AND JUST LAST WEEK SHE DEVELOPED AN EYE INFECTION AND I HAD TO TAKE HER TO THE EMERGENCY ROOM. THE BILL FOR THAT IS OVER $75. I DON'T KNOW WHAT I'D DO IF MY MOTHER DIDN'T HELP ME OUT. I LIVE WITH THE CONSTANT FEAR THAT SOON SOMETHING WILL REALLY GO WRONG.

EVERY SUMMER MY SON LE-PAUL BREAKS OUT IN A FACE RASH, THAT IS QUITE UNCOMFORTABLE. LAST SUMMER, I TOOK HIM TO THE HEALTH DEPARTMENT. THEY TOLD ME IT WAS AN ALLERGY AND THAT HE SHOULD GET A SERIES OF DIAGNOSTIC TESTS DONE. AFTERWARDS, I TOOK MY SON TO HIS DOCTOR FOR HIS ASTHMA, BUT THE DOCTOR REFUSED TO TAKE HIM AS A PATIENT UNTIL I PAID MY OUTSTANDING BILL OF NEARLY $400. SO I'VE HAD TO PUT OFF THESE ALLERGY TESTS TOO, UNTIL I CAN GET UP THE MONEY TO PAY FOR IT.

I'M AFRAID TO GET SICK, NOT ONLY BECAUSE OF THE BILLS BUT I CAN'T AFFORD TO MISS WORK GIVEN THE LITTLE MONEY I EARN. I DON'T KNOW IF ANY OF YOU HAVE FAMILY IN A NURSING HOME, BUT IT'S VERY HARD WORK. WE DO A LOT OF HEAVY LIFTING AND OUR BACKS COULD GO OUT AT ANY TIME. MY LOWER BACK HURTS BUT I HAVEN'T BEEN TREATED YET. WORKING IN A NURSING HOME ALSO EXPOSES YOU TO A NUMBER OF DISEASES. FOR EXAMPLE, RIGHT NOW A STAPH INFECTION IS GOING AROUND. IF I BRING IT HOME AND MY KIDS GET IT, WHO WILL PAY FOR THEM?

EVERYTIME THE UNION GOES TO THE BARGAINING TABLE -- THEY ASK FOR HEALTH INSURANCE. MY EMPLOYER ALWAYS ARGUES THAT IT'S GOING TO COST US A TEN CENT RAISE. MY EMPLOYER JUST DOESN'T WANT TO PAY FOR INSURANCE - SAYS HE CAN'T AFFORD IT. YET, HE'S BUSY REMODELING TWO NURSING HOMES.

I TRY TO GO TO A CLINIC WHERE IT'S THE CHEAPEST, NOT NECESSARILY WHERE I KNOW I CAN GET THE BEST CARE. STILL THE BILLS ARE HIGH. SO, IT'S EITHER FEED THE KIDS OR PAY THE DOCTOR'S BILL, AND IT'S NOT FAIR THAT I SHOULD HAVE TO FACE THAT CHOICE.

I TAKE HOME APPROXIMATELY $344 EVERY 2 WEEKS - THAT'S ABOUT $690 PER MONTH. AFTER RENT, ELECTRIC AND GAS BILLS, PHONE BILLS AND FOOD, I'M LEFT WITH $90. THEN, THERE'S STILL CLOTHING, TRANSPORTATION, CAR EXPENSES, SCHOOL SUPPLIES FOR THE KIDS, AND TAXES THAT MUST BE PAID OUT.

HOW AM I SUPPOSED TO PAY FOR HEALTH CARE?

I'M NOT ALONE - THESE HARDSHIPS ARE SHARED BY THE MAJORITY OF MY CO-WORKERS WHO ARE ALSO UNINSURED. SOME OF THESE WOMEN HAVE WORKED 15 YEARS AT THIS NURSING HOME AND THEY KNOW THAT OUR EMPLOYER WILL NEVER GIVE US HEALTH BENEFITS. THE REASON IS NOT ECONOMIC, IT'S JUST THAT HE WON'T.

I HOPE THAT IS ABOUT TO CHANGE. THANK YOU FOR YOUR TIME.

The CHAIRMAN. Let me turn to Ms. Lipowsky. You are working for the county government, is that correct?

Ms. LIPOWSKY. Yes, I am.

The CHAIRMAN. And did you say that the county government does not contribute anything to a health insurance plan for its employees.

Ms. LIPOWSKY. They contribute nothing. They do give us access to an HMO plan, and for myself it would cost over $79 just for myself and for my family there would be a discount, it comes to $214 a month, which is entirely too much to pay on insurance.

The CHAIRMAN. So they make it available, a group health plan, but you would have to pay for the entire premium yourself?

Ms. LIPOWSKY. Pay the full coverage, yes.

The CHAIRMAN. We have a copy here of the insurance company's form letter which I guess they sent to all of the county's employees last year. It says for a family of three, you would have to pay $214.

Ms. LIPOWSKY. Correct.

The CHAIRMAN. Is that what it would have cost you?

Ms. LIPOWSKY. Yes.

The CHAIRMAN. And your employer, the county government, would not contribute anything. We will make that a part of the record.

[The material referred to follows:]

HELEN LIPOWSKY'S HOUSEHOLD BUDGET:

EXPENSES		WAGES:	$804
Food:	$250		
Utilities (Average):	$125		
Car Insurance and gas:	$125		
Water and Sewage:	$ 20		
Phone Service:	$ 25		
Clothes and Children's Expenses:	$ 75		
Taxes on your house:	$ 50		
Payment of medical expenses:	$ 25		
Incidental household and miscellaneous:	$ 70		
TOTAL EXPENSES =	$765	WAGES:	$804

Total Income = $804
−Total Expenses = $765

Balance = **$39**

Health Insurance Would Cost = $214

The CHAIRMAN. How in the world could they possibly expect that you could join a health plan on your salary? I think before you came here today, you gave us a list of your monthly expenses. We will put all of that information up on this chart up here, that you can see behind me.

Your take-home pay you said is $804 a month.

Ms. LIPOWSKY. Correct.

The CHAIRMAN. Now, you have your food as $250—how many are there in your family?

Ms. LIPOWSKY. Three.

The CHAIRMAN. Three. All right, now food is $250 a month. Your utilities average $125, your car insurance and gas, $125, water and sewer, $20, phone service, $25, clothes, and children's expenses, $75, taxes and insurance on your house, $50, payment of medical expenses, $25, incidental house and miscellaneous, $70. So that adds up to $765. That leaves you $39 as a balance, and your health insurance would have cost you $214.

Ms. LIPOWSKY. Correct. It is slightly impossible.

The CHAIRMAN. It is virtually impossible to be able to swing that. Well, I think this makes the case. How many hours a week do you work?

Ms. LIPOWSKY. Forty.

The CHAIRMAN. How long have you worked for the county?

Ms. LIPOWSKY. I have been there a little over 11 years.

The CHAIRMAN. Eleven years, 40 hours a week, and virtually no kind of coverage in terms of health insurance, and this is county government. We have a nursing home which should be sensitive to health care needs, and we have a county government that has to be realistic in terms of what they are paying versus what the costs of living are and what the needs are.

[The prepared statement of Ms. Lipowsky follows:]

STATEMENT OF HELEN LIPOWSKY

Good Morning. My name is Helen Lipowsky and I am from Danville, Illinois. I would like to express my sincere gratitude to this Senate Committee and especially Senator Kennedy for having these hearings.

In Danville, where unemployment is still 15%, on one hand I am fortunate to be working, however, I fall in a category of people who have no health insurance. I work for Vermilion County in the County Clerk's office in Danville and make $804 a month and my daughter receives $266 in Social Security from her father's death, which is used to pay off outstanding loans. I live with my daughter and son. Presently, my employer does provide access to health insurance, but refuses to pay for any of it. The insurance offered costs $79.96 per person, which would cost me $214 a month. This translates to 25% of my monthly income, an amount which is impossible to pay for.

This leaves me with only two options. One, I go without it and face the consequences of being denied health care by local hospitals and doctors. The other option, is to try to purchase health care insurance elsewhere, which only covers limited services and if you are hospitalized, hopefully the insurance would pay for it. At least I would not be denied care, but I would still be faced with unsurmountable bills.

Not wanting to be faced with being denied health care, I chose the second option and now my family is faced with medical bills which will haunt me for the rest of my life. In 1984, I found myself in need of surgery to remove tumors from my female organs. These bills amounted to over $6,000. Shortly after

that, my son and daughter needed urgent medical treatment - outpatient care - for feet disorders, which amounted to another $1,500. My second class health care policy would only pay for $2,000 of the total $7,500. I was faced with over $5,500 in medical bills to pay and living on $804 a month is impossible to pay for them.

To begin paying for these bills, I first had to drop my inadequate health care insurance policy, which cost $65 a month. I am fortunate to own my home, but the fear that the hospitals and doctors would force me to mortgage home my passed through my mind too often. For over 1 1/2 years I could only afford to pay $25 a month, however, each month the hospital's service charges were $27 a month. After struggling with the hospital regarding what I could and could not pay, the hospitals decided to drop the interest payments, however, I had already paid them nearly $500.

I am still well over $4,000 in debt to the hospital and doctors and can still only pay at the most $25 a month. But when the high utility bills come in the winter, those medical payments must end. Presently, I am in need of major surgery again, for the same type of operation I had in 1984, but I can not afford it and the longer I prolong it, the longer it will adversely effect my overall health.

Thank-you Senator Kennedy and members of this Committee for giving me the opportunity to tell you about my situation.

The CHAIRMAN. Ms. Pettiford, we are glad to have you here.

Ms. PETTIFORD. Thank you. I would like to read my statement.

The CHAIRMAN. You have something that you want to say.

Ms. PETTIFORD. Yes.

My name is Nina Pettiford. I am a 39-year-old single parent of two children. My daughter Kim is 16 and my son Charles is 15. I work as a janitor at two Mellon Banks in Pittsburgh, Pennsylvania. I am employed by Arcade Maintenance, Inc., a building service contractor. I am a member of the Service Employees International Union, Local 29.

I used to have a "good job" that paid a "living" wage and benefits. As janitors at Mellon Bank headquarters in Pittsburgh, we counted on about $250 a week, plus health insurance and a small pension until February 1986. Then my wages were reduced to the point where now I am averaging about $100 in take-home pay. Even though many of us have cleaned this building for 15, 25 and 30 years, our health insurance and pensions were eliminated.

For the past six months, we have held onto our jobs and kept our families together by qualifying for unemployment compensation to subsidize our take-home pay.

Now the unemployment compensation has run out and my finances are tight. I lost my apartment and moved back home to live with my mother. My family has been split up. My teenage daughter Kim lives with me. My son Charles had to go live with his father. Money goes for food and other bare necessities. Worst of all is the loss of my health insurance.

My daughter Kim has both asthma and a heart murmur. These two conditions together are a nightmare. Recently, Kim had her impacted wisdom teeth removed. She was treated in the hospital and had a reaction to the anesthesia and her heart stopped. I am not able to afford regular doctors' visits and the tests that are needed to monitor her condition.

My son Charles is a special needs child who was receiving therapy. Once my health insurance stopped, these treatments were unaffordable. Charles gets public assistance but that does not cover his treatments.

I also have my medical problems. I have developed shingles which the doctors say is likely related to all the stress and anxiety that I have had over the last half year. And last month, the doctors told me that I have a uterine condition and I need surgery. None of the doctors at the Central Medical Pavilion, a public clinic in Pittsburgh, will perform the operation, because I do not have insurance. I am still trying to get an appointment at a women's hospital across town.

Believe me, going to a public clinic is a lot different than having your own doctor. You do not have someone you know. You have to explain your whole life history every time you go. Of course, you have really long waits and they have to schedule you a long time in between visits.

I even looked into trying to get private health insurance like the one I had before. I looked into Blue Cross and also Health America. But the cheapest I could find for a family of three was $160 a month, nearly two weeks' pay.

This is totally beyond my reach. After paying for food, bus passes for me and my daughter, rent, telephone, and storage of my furniture, I am left with $5 a month after-tax at most.

So, you see, this leaves very little left to do anything. We do not go to the movies. We do not buy new clothes. So you can see money for health care since Mellon Bank cut off my health benefits is money I do not have.

I also do not have money to pay off some of the old medical bills. I brought some bills with me today—$364 for Kim's asthma treatments, $260 for my son's treatment, and over $90 for doctor visits for myself. I have to resist the urge to rip these bills up because sometimes I feel that is the only way I am going to get rid of them.

I have no problem coming here today and telling you about my troubles, because I think a lot of people have the same troubles. I used to have a good job, live in a nice house and be able to support my two children.

That has all changed, thanks to our employer's efforts to make us part-time workers. No health insurance, no pension, we are now the flexible workforce of the 1980s.

As a woman and a mother, I feel a little bit like a failure. I have always had my children with me. I have worked hard to give them a good life, but now there is always so much anxiety and there is always more bills.

I pray to God, Senator Kennedy, that your efforts to find a solution that will help my family are successful.

I would also like to take this opportunity to thank the press and the Committee and the staff for giving us Americans the opportunity to tell you what is happening to us. Thank you again for allowing me the opportunity to be here today. I would be happy to answer any questions you might have.

The CHAIRMAN. Thank you very much, Ms. Pettiford.

As I understand, you usually end up with about a balance of $5 a month, is that right?

Ms. PETTIFORD. Yes, sir, that is right.

The CHAIRMAN. Obviously, there is no way in the world that you can afford to buy health insurance on that balance. You have demonstrated the kind of anguish and concern that parents have when one of their children is ill or needs attention. We have heard that mentioned earlier this morning. It is a very real anguish and it is the same the world over, but this is one that is certainly avoidable. There are many problems in our society that we have difficulty dealing with, but we know how to deal with this one, and we ought to be willing as a society to come to grips with it.

I want to thank each of you. As I mentioned at the outset, it is always difficult to talk about the problems that you have in your families and the needs of your children. But we have individuals here who all have worked hard a good part of their lives and who take pride in providing for their children, and here we find that they are just not able to purchase health insurance to relieve them from their anguish and pain and I think that they speak for millions and millions of people.

We found that of 37 million Americans who lack health insurance, we would cover 24 million with this legislation. We would be covering both the people who are working and their dependents.

We still have to deal with the others who would not be covered, and we have some ideas about how to do that also.

I want to thank all of you very much for sharing. I want you to know that we have heard your message, we will share it with the other members of the Committee and we will do everything we can to try and make this legislation into law.

Thank you very much.

We will go right on to the next panel. We will ask Jack Owen, Executive Vice President for Public Affairs, American Hospital Association; Mary Wilhelm, The Catholic Health Association; and Jerold Aronson, American Academy of Pediatrics.

Jack, we will start off with you. We will include all of your statement in the record. As I mentioned earlier, we are going to be interrupted here shortly with votes, but we have got an important message, and the American Hospital Association is an important organization. So we want to hear from you, but we would ask you if you would be good enough to summarize.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; SISTER MARY E. WILHELM, CHAIRPERSON-ELECT, BOARD OF TRUSTEES, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES; AND DR. JEROLD ARONSON, ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

Mr. OWEN. Thank you, Mr. Chairman. I would be happy to summarize, since my testimony will become part of the record.

The American Hospital Association applauds you and your colleagues for moving forward and bringing this whole subject of medical indigence before the Nation. Our great concern with the growing problem of medical indigence stems from the fact that 53 percent of the Nation's more than 35 million uninsured are fully employed, and any proposal that would mandate employer-provided health insurance is of major interest to us.

Medical indigence is a complex, multi-faceted issue that has no single or simple solution. But the public expects needed care to be provided, regardless of a patient's ability to pay, and all members of society must participate in the financing of care provided to the medically indigent. This public responsibility does not mean, however, that government alone can or will resolve the problem. An enduring solution to the problem of medical indigence will require initiative by both public and private sectors: first, to reduce the size of the medically indigent population through adequate private health insurance; and, secondly, to restructure and extend public programs to finance care for the medically indigent who are unable to obtain private insurance, and I think you have mentioned that several times this morning.

The number of people falling through the cracks of the private and public insurance system is growing. Of the 35 million non-elderly uninsured, 53 percent, as I said, are fully employed, and another 34 percent are employed on a part-time basis. Meanwhile, cost containment efforts among public and private payers have limited hospitals' authority to provide uncompensated care to the medically indigent.

In 1985, uncompensated care costs hospitals over $7.4 billion, a jump from $3.5 billion in 1980. Although local tax appropriations on hospitals to defray some of the costs, $6.3 billion in 1985 medical costs were truly unsponsored. Hospitals, therefore, had to absorb these expenses or in limited circumstances pass them on to other patients in the form of higher charges.

Given the urgency and magnitude of the problem of medical indigence, the American Hospital Association supports a mandated approach as the best way to achieve effective solutions over the short and long term.

The U.S. health system currently is built on employer-provided insurance. About 85 percent of the 191 million privately insured patients now receive insurance through the work-place, and Federal and State tax policies clearly support this pattern. There is a strong argument for extending coverage to those people who are not covered by extending the existing system of employer-provided insurance.

We think a mandated insurance program would bring greater equity for those workers who do not have insurance, yet through taxes are supporting the health insurance of others, bring greater equity to employers who do insure their employees because they subsidize through cost shifts, coverage of working spouses, employers who do not insure their employees; and lower the insurance costs to small employers by giving them a greater value for their insurance dollar. Though mandating benefits has many advantages; it may also pose some economic problems, and I think you brought those up, particularly for small employers, and we hope that you will minimize any side effects of this mandated policy, and I am sure you will.

We think that carefully designed programs could be a significant step to address the issue of medical indigence without causing any undue economic hardship for employers. Although mandating is a powerful means of reducing the magnitude of the problem of medical indigence, it is not a panacea. Millions of Americans will continue to rely on public programs and the design of a mandate itself raises a number of significant issues.

If government is to adopt the principle that insurance is a condition of doing business, then government also has an obligation to make compliance with the principle a practical reality.

The comprehensive solution to the medical indigence problem requires an expansion of insurance options in both private and public sectors and will require the cooperation of the government, employers, providers, insurers and the hospitals themselves.

We look forward to working with you, with the Committee, in designing this proposal and we hope that it will move forward.

Thank you very much, Senator.

[The prepared statement of Mr. Owen and a statement on behalf of the American Hospital Association, follow:]

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STATEMENT BY JACK W. OWEN

EXECUTIVE VICE PRESIDENT

AMERICAN HOSPITAL ASSOCIATION

MAY 19, 1987

The American Hospital Association applauds Senator Kennedy and his colleagues for their efforts to continue focusing the nation's attention on the problem of medical indigence. An increasing number of people are falling through the cracks of the private and public insurance system. Of the 35 million non-elderly uninsured, 53 percent are fully employed and another 34 percent are employed on a part-time basis. Cost containment efforts among public and private payers have limited hospitals' ability to provide uncompensated care to the medically indigent.

Nonetheless, in 1985, uncompensated care cost hospitals $7.4 billion, more than double the $3.5 billion spent on such care in 1980. Although local tax appropriations to hospitals defrayed some of this cost, $6.3 billion in 1985 medical care costs were "unsponsored." What happens to those costs? In most

cases, hospitals absorb them or, in limited circumstances, pass them on to other patients in the form of higher charges. This situation cannot continue without jeopardizing access to and quality of health care for all Americans. Therefore, the American Hospital Association supports, in concept, a mandated health benefits approach as the best way to achieve effective solutions over the short and long terms.

The U.S. health insurance systems currently is built on employer-provided insurance--about 85 percent of the 191 million privately insured Americans now receive insurance through the workplace. Because 53 percent of the uninsured are employed, a mandated approach could extend coverage to these people by extending the existing system of employer-provided insurance. Mandating benefits, as an option, has many strong advantages. But mandated coverage also has some economic problems. Consequently, it is important to minimize adverse side effects. A carefully designed mandate could be a significant step to address the issue of medical indigence without causing undue economic hardship for employers, particularly small employers.

A workable approach would require:

- o Carefully-defined mandates, with a minimum amount of regulatory intrusion required to implement them.

- o Inclusion of features designed to minimize economic dislocations caused by the mandate. Features should include:

-- A widely available, affordable insurance product;

-- Gradual, phased-in mandates; and

-- Significant tax relief and other subsides.

If government is to adopt the principle that insurance is a condition of doing business, then government also has an obligation to make compliance with the principle a practical reality.

We look forward to working further with the committee in designing a proposal to close the gap in our public and private insurance system and ensure access to care for the working poor and their families.

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION
TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
OF THE
UNITED STATES SENATE
ON
MANDATED EMPLOYER INSURANCE

May 19, 1987

SUMMARY

A comprehensive solution to the medical indigence problem will require an expansion of both private insurance options and public-sector programs. It will require the cooperation of government, employers, providers, insurers, and the uninsured themselves. Because 53 percent of the uninsured are fully employed, the expansion of private group-based coverage could reach a large portion of the uninsured.

Private coverage could be expanded through strong incentives or mandates. Both approaches require development of more affordable insurance options coupled with tax relief and other public support. Given the urgency and magnitude of the problem, the American Hospital Association supports, in concept, a mandated approach as the best way to achieve effective solutions over the short and long term. A workable mandating approach would require:

o Carefully-defined mandates, with minimal regulatory intrusion.

-- Required insurance should cover a carefully defined set of services, with requirements applied to self-insured as well as privately-insured businesses.

-- Mandates should apply only to permanent employees, who would be covered after a short waiting period. Required employer contributions should be greater for full-time than for part-time employees.

o Inclusion of three features designed to minimize economic dislocations:

-- A widely available, affordable insurance product;

-- Gradual, phased-in mandates; and

-- Significant tax relief and other subsidies.

We look forward to working further with the committee in designing a proposal to close the gap in our public and private insurance system and thereby help ensure access to care for the working poor and their families.

INTRODUCTION

Mr. Chairman, I am Jack Owen, executive vice president of the American Hospital Association (AHA) and director of the Washington Office. On behalf of our 5,600 institutional and 40,000 personal members, the American Hospital Association is pleased to have this opportunity to present our views on mandated employer insurance. Because of our great concern with the medical indigence issue and because 53 percent of the nation's 35 million uninsured are fully employed, any proposal that would mandate employer-provided health insurance is of major interest.

Medical indigence is a complex, multi-faceted issue that has no single or simple solution. Because the public expects needed care to be provided regardless of a patient's ability to pay, all members of society must participate in the financing of care provided to the medically indigent. This public responsibility does not mean, however, that government alone can or will resolve the problem. An enduring solution to the problem of medical indigence will require initiatives by both public and private sectors to:

- o Reduce the size of the medically indigent population through adequate private health insurance; and

- o Restructure and extend public programs to finance care for the medically indigent who are unable to obtain private insurance.

Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, the report of the AHA Board's Special Committee on Care for the Indigent, outlined a series of public and private initiatives to address the medical indigence problem. In other testimony before Congress, we have commented on this overall approach. Because this hearing focuses on the mandated employer insurance question, however, this statement examines private-sector solutions, and in particular, the possibility of requiring employers to offer insurance to their employees.

HEALTH INSURANCE COVERAGE OF THE EMPLOYED

The U.S. health insurance system currently is built on employer-provided insurance. About 85 percent of the 191 million privately insured Americans now receive insurance through the workplace, and federal and state tax policies clearly support this pattern. In 1982, federal and state governments provided a $31 billion subsidy of the privately insured through exclusion of employer-paid health insurance from the taxable income of employees.

Nevertheless, 53 percent of the uninsured have a full-year, full-time link to the workplace, and another 34 percent are linked to the workplace on a

part-time or intermittent basis. A recent analysis by the Employee Benefit Research Institute shows that, of the 34.8 million non-elderly uninsured in 1985:

- o 52.3 percent lived in families headed by full-year, full-time workers;
- o 8 percent lived in families headed by full-year, part-time workers;
- o 17.2 percent lived in families headed by sometimes unemployed workers;
- o 9.2 percent lived in families headed by part-year workers; and
- o only 13.5 percent lived in families headed by nonworkers.

In combination, these statistics lead to two conclusions. First, the favorable tax treatment of health insurance benefits has facilitated high levels of private insurance coverage. Second, even current tax incentives are inadequate to induce a sizeable number of employers to offer private insurance coverage through the workplace.

PROPOSALS TO MANDATE EMPLOYER-PROVIDED INSURANCE

Recently, some have questioned whether anything short of a legal mandate to employers will have much effect in extending private insurance coverage to the employed uninsured and their families. At the AHA's annual meeting in

February 1987, Senator Edward Kennedy said that "the time has come to require all businesses in America to offer insurance to all their workers--and their dependents too--as a condition of doing business." We understand that the proposal under consideration by this committee, will require all employers to provide a minimum health insurance package to all full-time employees and their dependents. Employees would have to accept the package unless they had other coverage meeting the minimum standards. Businesses with 25 or fewer workers would be required to join a new regional or statewide insurance pool. Through this pool, termed a "structured choice," private insurance companies chosen through competitive bidding would offer several alternative plans ranging from the minimum required to more generous packages.

Historically, the AHA has preferred strong incentives and joint private/public sector action to induce employers to offer insurance to their employees because of possible economic problems that could arise from a mandated approach. Such incentives might include:

- o Insurance pools for small businesses and the employed uninsured, possibly using Medicaid as the pool;

- o Positive income tax incentives (100 percent deductibility of health insurance costs for self-employed and owners of unincorporated small businesses);

- o Negative income tax incentives (such as payroll or excise taxes on non-insuring businesses);

- o Employer subsidies;

- o Legal relief from state-mandated minimum benefit laws.

Very recently, AHA has modified its position on mandated employer insurance in recognition that the number of people falling through the cracks of the private and public insurance system is growing. At the same time, cost containment efforts among public and private payers have limited hospitals' ability to provide uncompensated care to the medically indigent. The growing number of uninsured suggests that incentives alone may not be strong enough to deal with some of the employer groups that do not provide insurance, unless they are so strong that little difference remains between incentive and mandated approaches.

Advantages of Mandating

Many policy arguments for mandated employer benefits can be made. Because the U.S. health insurance system currently is built on employer-provided insurance, and because 53 percent of the uninsured have a full-time, full-year link to the workplace, there is logic to the idea of extending coverage to some of these people by building on the existing system. Other advantages to the mandating approach include:

- o Equity for employees. At present, workers not offered insurance are paying some of the $31 billion in taxes that are used to subsidize

health insurance for other, generally higher-paid, workers. If employer-provided coverage were required, this would no longer be the case.

- o Equity for employers. Currently, employers who insure their employees are subsidizing those who do not, both through cost shifts and through coverage of working spouses. Many proposed solutions, such as insurer-subsidized risk pools and provider-subsidized uncompensated care pools, would continue this cross-subsidy. With mandating, employers, who are now contributing to the problem, would be required to contribute to the solution.

- o Economy. Presently, small employers who insure their employees have higher insurance costs and often fewer benefits. This happens because small business insurance policies have higher relative administrative and marketing costs and because insurers fear "adverse selection" through higher rates of enrollment by businesses with high-risk employees. Facilitating the development of pooling arrangements by the public or private sectors or both would mitigate these problems and could give all small businesses, including those who already insure their employees, more value for their insurance dollar.

Disadvantages of Mandating

A strong economic argument also can be made that mandated coverage is no

panacea. By itself, mandating could cause serious economic dislocations, particularly for small businesses.

- o Expense. Health insurance is a relatively expensive benefit under the best of circumstances. A recent survey by the health group division of Johnson and Higgins found that average employer health care costs totaled $1,837 per worker in 1986. These costs could be reduced by providing coverage for catastrophic expenses only and could be reduced further by using economies of scale discussed previously. In firms already offering other, non-health benefits or paying employees significantly above the minimum wage, some of the new health benefit costs could be offset by reducing other benefits or by sharing the premium between the employer and employee.

- o Effect on jobs and small businesses. For firms operating on a tight budget or paying employees at the minimum wage, mandated health insurance could force them to reduce staff levels, move employees from full-time to part-time status, or go out of business. Although it is unclear how many businesses would face these choices, available data show that most of the currently uncovered workers are employed at low wages and in relatively small firms.

  -- In 1985, 2.5 million uninsured workers had hourly earnings between 100 and 125 percent of the minimum wage, and 4.5 million had hourly earnings between 125 and 200 percent. Together,

these two groups accounted for 42.5 percent of all uninsured workers.

-- Another 5.8 million, or 35.2 percent of uninsured workers, earned less than the minimum wage in 1985. Depending on how the law was written, employers might be forced to cover some or all of these workers, thereby increasing labor costs.

-- Nearly half of uninsured workers are in firms with fewer than 25 employees.

Although there are strong advantages to a mandated approach, there are also many serious economic consequences. The decision to mandate depends on how effectively a given proposal would achieve a desired end while minimizing adverse side effects. For this reason, it is important to consider what a mandating policy would have to include to reap advantages and avoid economic problems of the mandating approach.

FEATURES OF A FEASIBLE MANDATING POLICY

Mandating is a politically appealing option because it enables government to address the problem of the medically indigent without any direct "on budget" expenditures. For mandating to work, however, employers must have the ability to comply. A workable mandating approach, therefore, would require:

- o Carefully-defined mandates, with a minimum amount of regulatory intrusion required to implement them and;

- o Inclusion of three features designed to minimize economic dislocations caused by the mandate:

  -- A widely available affordable insurance product;

  -- Gradual, phased-in mandates; and

  -- Significant tax relief and other subsides.

A carefully designed mandate could be a significant step to address the issue of medical indigence, without causing undue economic hardship for employers. Mandating insurance, however, is no panacea, particularly for the millions of Americans with only a tenuous relationship to the job market.

Definitions

The first requirement of a successful mandating policy would be a very careful and deliberate series of decisions about its boundaries and structure:

- o Definition of benefits. In requiring employers to purchase insurance, the law would have to define what is meant by insurance, that is, to describe a minimum package. This means that any mandated employer

benefit proposal could--and probably should--result in a federal preemption of state authority to regulate the content of insurance packages. Determination of this minimum package will be the single-most important decision affecting the economic feasibility and policy results of any mandated benefit package. The more generous the required package, the greater the potential hardship for business and the greater the risk of business closures and employee layoffs. On the other hand, if the minimum package were pared back too far, the new employee benefit would be largely illusory. It also should be noted that the definition of insurance adopted for purposes of a mandated employer insurance law also could affect the content of existing employee benefit packages. The law also would apply to self-insured businesses heretofore exempt from state mandates. Under the Employee Retirement Income Security Act (ERISA), self-insured businesses are subject to federal, but not state, insurance regulation.

AHA believes that required insurance should cover a carefully defined set of services and that requirements should apply to self-insured as well as privately-insured businesses. States should not be permitted to add additional requirements to federal mandates. If they do, the cost of mandated insurance may rapidly increase beyond the means of small employers. In order to avoid unnecessary federal government involvement in insurance regulation, the benefit package should be keyed to Medicare and/or Medicaid benefits.

- Definition of employer. The law could be applied to all businesses or it could exempt businesses of a certain size. It also could exempt employers on some other basis such as type of industry, profit level, subjection to minimum wage laws, etc. AHA believes that larger and more profitable businesses should be phased in first.

- Definition of employee. The law could include all employees or only those working full time, or on a permanent basis. We recommend that the law apply only to permanent employees, who would be covered after a short waiting period. All permanent employees should be offered group coverage, but the minimally required employer share of the premium could be greater for full-time than for part-time employees.

- Definition of "employer-provided" insurance. The required employer share could be set at any point between 0 and 100 percent, and could be set at different levels depending on factors such as business or payroll size. Though AHA believes employers have a responsibility to offer health insurance coverage to their employees, the extent to which employers should be required to pay for such coverage remains an open question. We suggest that the employer share increase over time and increase with business or payroll size.

Minimizing Economic Disruption

A further aspect of mandating concerns the type of government programs needed to ensure the availability of affordable insurance coverage. In addition to

carefully defined employer mandates, any policy requiring employers to provide health insurance must take steps to minimize economic dislocations and facilitate employer compliance. The cost of insurance is, for many employers, a major barrier to the extension of health benefits to their employees. A 1985 National Federation of Independent Business survey found that most employers had considerable interest in insuring their employees, but that the main reasons for not offering insurance were high premiums (33 percent), high employee turnover (15 percent), coverage under spouse or parent policy (26 percent), insufficient firm profits (20 percent), and inability to qualify for a group policy (19 percent). (Respondents could give more than one reason.) These results suggest mandated insurance coverage must be accompanied by the development of lower cost forms of insurance, the phased implementation of mandates, and possibly some financial support.

To some extent, the very existence of mandates could lower costs. If all employers were required to provide insurance, the adverse selection problem would be mitigated somewhat. Moreover, replacing state mandates with a carefully-drawn single federal standard could reduce premium costs further. Finally, most of the current mandated employer insurance proposals also call for various pooling arrangements designed to lower administrative costs, particularly for small employers. Such arrangements might include both "public" sector pools for high-risk individuals subsidized by insurers--as now exist in 11 states--and private pools for individuals or small groups wishing to purchase coverage. To facilitate private-sector pooling, legal barriers to the establishment of pooling arrangements by insurers or employers should be

identified and eliminated. Medicaid also might be used as a "pool" for individuals wishing to "buy in" to the program.

Economic dislocations could be further minimized by the phased implementation of mandates. One way to phase in mandates would be to require employers to offer insurance but phase in the employer share of the premium. The initial minimum employer share could be set very low, then gradually increased on a scheduled basis.

Because some employers would find it easier to comply with mandates than others, mandatory coverage might be phased in by employer category. For example, in a 1985 National Federation of Independent Business survey, 10 percent of businesses with over 100 employees and 6 percent of businesses with more than $10 million in gross receipts indicated that they provide no employee health insurance. All things being equal, these businesses would find it easier to provide insurance than would firms with 1-4 employees or less than $100,000 in annual gross receipts. Several types of phased-in mandates geared to employer characteristics could be established.

Although decisions about administrative structure and product design could lower costs somewhat, remaining premiums would still present a hardship to some employers. If the mandate were phased in properly, employers facing the greatest hardship would be brought in last. Even a phased-in approach, however, would present problems for some employers. It is clear that at some point those employers would need public support to survive. This support might be provided by:

- o Tax relief. The self-employed and owners of unincorporated small businesses can deduct only 25 percent of their own health insurance costs. Increasing the deduction to 100 percent would put these small businesses on a par with larger ones and make insurance more affordable. For very small businesses, or those with very low profit margins, a tax credit would provide an even stronger incentive.

- o Employer subsidies. For employers with low profit levels, changes in tax structure cannot provide a strong incentive. For these firms, Congress might provide for partial subsidies. These could take the form of direct subsidies to employers, as is done in Hawaii, the only state which currently has employer-mandated insurance. Alternatively, it could be done by varying the premium under the general state pool. In either event, one logical source of financing would be the tax revenues derived from the health insurance provisions in the Tax Reform Act of 1986. (In cases where employers provide a high level of benefits to some employees and less or no benefits to others, the Tax Reform Act calls for inclusion of the "discriminatory excess" in the gross taxable income of the highly compensated employees.)

In combination, these actions could substantially reduce the possible economic disruption that mandatory extension of insurance coverage could cause. Some of these actions will be necessary if all employers are to be able to comply with the mandates. If government is to adopt the principle that insurance is a condition of doing business, then government also has an obligation to make compliance with the principle a practical reality.

CONCLUSION

A comprehensive solution to the medical indigence problem will require an expansion of insurance options in both the private and the public sectors and require the cooperation of government, employers, providers, insurers, and the uninsured themselves. Because 53 percent of the uninsured are fully employed, any approach geared to expanding private group-based coverage has the potential to reach a large portion of the uninsured. Although mandating is a powerful means of reducing the magnitude of the problem of medical indigence, it is not a panacea. Millions of Americans would continue to rely on public programs. And the design of a mandate itself poses a number of significant issues.

We look forward to working further with the committee in designing a proposal which will help close the gap in our public and private insurance system and thereby help assure access to care for the working poor and their families.

The CHAIRMAN. Thank you very much.

We will hear from all of the panel. We welcome Sr. Eileen Wilhelm, who is the Chairperson-Elect of the Board of Trustees of The Catholic Health Association and, President of Mercy Medical, Daphne, Alabama. Sr. Eileen represents The Catholic Health Association of the United States which has always felt a particular mission to serve the poor, and she brings that special sense of mission as well as long experience in the front lines of health care. She is with us today and we look forward to hearing her testimony.

Sr. WILHELM. Thank you very much, Senator Kennedy.

On behalf of CHA, whose membership includes more than 900 health care facilities, I am grateful for the opportunity to appear before you this morning to support strongly and enthusiastically the concept of a minimum health care law. I want to congratulate you personally for the leadership role you have played for so many years in the quest to assure access to an adequate level of health care services for every American.

I have come to realize that the American health care system is made up of thousands of professionally and personally dedicated care-givers in hundreds of distinguished hospitals and nursing homes using the most advanced and sophisticated medical technologies.

In spite of the justifiable pride I feel in the service which I and so many other health care professionals have rendered, I am deeply troubled that millions of people in this country still do not have access to necessary or adequate health care services; such a stark reality raises fundamental questions in my mind about the system's integrity from the point of view of justice.

The most recent survey on the subject, entitled "Access to Health Care in the United States: Results of A 1986 Survey," published in a Robert Wood Johnson Foundation special report, sheds distressing light on the problems of accessing our Nation's health care system and raises questions about how the new competitiveness in health care affects the availability of that care for those who most need it.

The report indicates that nearly one million poor uninsured Americans last year failed to receive necessary medical services and cites a dramatic decline in the use of physician and hospital services by the poor. The Robert Wood Johnson Foundation report cautions that "there has been a serious deterioration in the care available to those groups most vulnerable."

Mr. Chairman, the current preoccupation with controlling health care costs, to the neglect of the other equally important goals of improved access and quality, is causing our Nation to renege on its long-standing and honorable commitment to provide for the health care needs of the less fortunate among us. This is a commitment premised in justice, not charity.

To respond to the alarming and growing incidence of medical indigency in the United States, a specially-formed Catholic Health Association Task Force last year completed a 15-month in-depth study entitled, "No Room in the Marketplace: The Health Care of the Poor." The report is a challenge directed first to Catholic health care facilities and other providers, then to the larger Catho-

lic Church in the U.S. and, finally, to government, to identify the means of expanding poor people's access to health care services.

The task force recommends a two-track interim strategy which includes the expansion of (1) Medicaid's benefit structure and eligibility requirements, and (2) private insurance at the State level. With regard to the latter recommendation, the report would require States to mandate that employers provide health insurance coverage for all their employees, just as they are required to pay unemployment compensation and social security.

Thus, CHA's present support for the idea of a Federal requirement that employers provide a minimum health insurance package to employees and their dependents is premised on the fact that it closely monitors one of the major recommendations of our task force regarding the necessary and essential involvement of government in searching for solutions to the problems of the health care poor. Likewise, that support is contingent upon adequate protection for the consciences of employers with respect to abortion. CHA does not believe that any employer should be forced by Federal law to provide abortion insurance coverage.

CHA is not unmindful of nor insensitive to the significant financial impact a mandatory, employer-paid health insurance package could have on a small business especially. We are pleased that your proposal attempts to minimize some of the difficulties small businesses could experience under mandatory coverage. This is an issue of extreme importance that deserves your most careful attention and analysis as this Committee continues to examine a method of requiring all employers to provide a minimum level of health care insurance.

The Catholic Health Association believes that a properly formulated minimum health law will go a long way toward ameliorating problems of 27 million working, but uninsured Americans and their dependents.

Thank you, Senator Kennedy. CHA pledges to continue to work with you and your staff in the legislative development of this important and praiseworthy concept. Already, 145 million Americans have health care insurance because of their employment; we need to build on this impressive foundation.

Thank you very much.

[The prepared statement of Sr. Wilhelm follows:]

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TESTIMONY

of

THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

in support of the concept of a

MINIMUM HEALTH CARE LAW

before the

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

Presented by

Sister Mary Eileen Wilhelm, RSM
Chairperson-Elect, Board of Trustees
The Catholic Health Association
of the United States

And

President
Mercy Medical
Daphne, Alabama

May 19, 1987

Good morning, Mr. Chairman and Members of the Committee.

I am Sister Mary Eileen Wilhelm, RSM, President of Mercy Medical in Daphne, Alabama, a specialized hospital offering hospice, rehabilitation and sub-acute medical intervention services to the citizens of southern Alabama, southern Mississippi and the Florida panhandle. Next month, I will become the Chairperson of the Board of Trustees of the Catholic Health Association of the United States (CHA).

Senator Kennedy, on behalf of CHA whose membership includes more than 900 health care facilities in every state of the union and in the District of Columbia, I am grateful for the opportunity to appear before you this morning to support strongly and enthusiastically the concept of a minimum health care law such as the kind you are proposing. I want to congratulate you personally for the leadership role you have played for so many years in the quest to assure access to an adequate level of health care services for every American. Furthermore, I applaud you and the members of this Committee for conducting this hearing on requiring employers to provide at least a minimum level of health care for all working Americans.

For the past twenty years, in one capacity or another, I have been daily involved in caring for the sick and aged in our society and in helping others to care for those whose illness or infirmity make them so vulnerable and in need of healing. Because of this personal experience, I have come to realize that the American health care system is made up of thousands of professionally- and personally-dedicated caregivers in hundreds of distinguished hospitals and nursing homes using the most advanced and sophisticated medical technologies.

In spite of the justifiable pride I feel in the service which I and so many other health care professionals have rendered, I am deeply troubled that millions of people in this country still do not have access to necessary or adequate health care services; such a stark reality raises fundamental questions in my mind about the system's integrity from the point of view of justice.

The well-known, oft-repeated litany of statistics regarding the health care poor and uninsured deserves even more repeating:

- o 37 million Americans are without health insurance for all or part of a year;
- o when those with inadequate insurance coverage are added, more than 50 million Americans face serious access problems each year;
- o 27 million are uninsured working Americans or dependents of employed persons;
- o 18 million uninsured Americans are married and over 30 years old;
- o the number of uninsured has increased 30 percent between 1980 and 1985.

The most recent survey on the subject, Access To Healthcare In The United States: Results of a 1986 Survey, published in a Robert Wood Johnson Foundation Special Report (No. 2/1987), sheds more distressing light on the problems of accessing our nation's health care system and raises questions about how the new competitiveness in health care affects the availability of that care for those who most need it. The report indicates that nearly one million poor or uninsured Americans last year failed to receive necessary medical services and cites a dramatic decline in the use of physician and hospital services by the poor. Americans in general, according to the report, are cutting back on their use of medical care. A 1982 survey

found that 19 percent of Americans, including the poor and uninsured, had not seen a doctor in the previous year; that percentage increased to 33 percent in 1986. The Robert Wood Johnson Foundation report cautions that "there has been a serious deterioration in the care available to those groups most vulnerable."

Mr. Chairman, several factors explain why ensuring the availability of health care services for the poor and uninsured has become such an urgent problem. A marketplace environment, driven by keen competition among health care providers, requires that persons pay for the services they need. Obviously, that is the very essence of competition! In such an environment there are few, if any, economic incentives to provide care for those unable to pay. The problem is further exacerbated by employers' and insurers' understandable efforts to bring their own health insurance costs under control by reducing payments to providers, thus limiting dollars previously available for the care of the poor. Lastly, unprecedented federal deficits, ill-conceived national budget priorities, and disproportionate budget cuts in health care reimbursement have aggravated the overall problem by seriously impacting such programs as Medicare and Medicaid.

The current preoccupation with controlling health care costs, to the neglect of the other equally important goals of improved access and quality, is causing our nation to renege on its long-standing and honorable commitment to provide for the health care needs of the less fortunate among us. This is a commitment premised in justice, not charity. In short, the health care poor and uninsured are one of the principal casualties in our nation's current deficit reduction

battle; the unbridled marketplace competitiveness, so appropriate in other areas of commercial enterprise, may in fact be the Achilles' heel of our present method of controlling health care costs and of allocating health care resources.

To respond to the alarming and growing incidence of medical indigency in the United States, a specially-formed Catholic Health Association (CHA) Task Force last year completed a 15-month indepth study entitled: No Room In The Marketplace: The Health Care Of The Poor. (CHA has distributed copies of the report previously to each member of this and other congressional committees.) Although the report primarily attempts to provide specific guidance to the Catholic health care ministry, its recommendations are not solely to a Catholic audience. It is neither a self-righteous indictment of others nor a self-congratulatory reflection on our own achievements. Rather, the report is a challenge directed first to Catholic health care facilities and other providers, then to the larger Catholic Church in the U.S., and finally, to government to identify the means of expanding poor people's access to health care services. Catholic caregivers are urged to renew their historic commitment to serving the poor in their management and hiring practices, in their educational and advocacy efforts, and especially in their planning and budgetary processes. For instance, the report urges CHA-member institutions to include in their annual corporate budgets a specific allocation of funds for charity care and to set patient income schedules higher than the federal poverty level in determining which patients are eligible for charity care in their hospitals and nursing homes.

The report's recommendations for government involvement in solving the problems of the health care poor and uninsured are integral to the comprehensive perspective of the Task Force. It recommends that in the long term the only way adequately to guarantee access to necessary health care services for the poor is to insure them all through a federally-mandated universal health insurance program. Until that ideal becomes more politically achievable, the Task Force recommends a two-track, interim strategy which includes the expansion of (1) Medicaid's benefit structure and eligibility requirements and (2) private insurance at the state level. With regard to the latter recommendation, the report would require states to mandate that employers provide health insurance coverage for all their employees, just as they are required to pay unemployment compensation and social security.

Thus, CHA's present support for the idea of a federal requirement that employers provide a minimum health insurance package to employees and their dependents is premised on the fact that it closely mirrors one of the major recommendations of our Task Force regarding the necessary and essential involvement of government in searching for solutions to the problems of the health care poor.

CHA is not, however, unmindful of, nor insensitive to, the significant financial impact a mandatory, employer-paid health insurance package could have on a small business especially. With you, Mr. Chairman, we are aware that small businesses pay premiums as much as 40 percent higher than those paid by large companies due to higher administrative and sales costs for serving such a small group of customers with a rapid turnover.

For that reason, we are pleased that your proposal attempts to minimize some of the difficulties small businesses could experience under mandatory coverage by establishing pooling mechanisms in geographic services areas which would provide competitive group rates and offer a range of benefit plans. From these the employer could choose any plan and pay the cost only for the least expensive plan. If an employer chooses not to pay the extra expense for a more comprehensive plan, the employee would have the option to pay the difference. Such special provisions for small employers would help to hold down costs by encouraging employers and workers to seek the best plan at the lowest cost. Nevertheless, this is an issue of extreme importance that deserves your most careful attention and analysis as this Committee continues to examine a method of requiring all employers to provide a minimum level of health care insurance.

The Catholic Health Association believes that a properly formulated minimum health law will go a long way toward ameliorating problems of 27 million working, but uninsured, Americans and their dependents. With the philosopher Spinoza, CHA believes that "care of the poor is incumbent on society as a whole." As part of that society, Catholic health care facilities taking a hard, introspective look at what contribution they are making to caring for the health care poor and invite other elements of our society, i.e., labor, business, government, consumers and providers, to do the same.

Thank you, Senator Kennedy, CHA pledges to continue to work with you and your staff in the legislative development of this important and praiseworthy concept. Already, 145 million Americans have health care insurance because of their employment; we need to build on this impressive foundation.

The CHAIRMAN. Thank you. That is very helpful.

Dr. Aronson, represents the American Academy of Pediatrics, and is a self practicing pediatrician. We look forward to your testimony.

Dr. ARONSON. Mr. Chairman, I am honored to appear and represent the Academy of Pediatrics to support your bill and compliment you for its introduction.

Of the millions of uninsured individuals, almost one-third are children aged 18 or under; of the uninsured children, 29 percent are dependents in families with employer-based insurance coverage; an additional 7 million children may only be insured for part of the year. Thus, while children represent only 29 percent of the population, they represent at times almost one-half of the uninsured.

As pediatricians, we are concerned because the lack of insurance is denying access to medically-necessary care, including preventive services for many children. Additionally, a disproportionate number of children who either have chronic disabilities or handicapping conditions are among the working poor and may be unable to obtain needed medical care, as we have heard eloquently this morning.

Existing data is distressing enough; however, the trends are even worse. The United Hospital Fund of New York cited a 23 percent increase in the number of New York State residents without health insurance coverage during the period 1980 to 1984. This occurred while the Medicaid rolls remained constant. Therefore, the growth in the number of the uninsured occurred entirely as a result of reductions in the numbers of individuals covered by private health insurance, despite that fact that the great majority of the uninsured were employed.

We have heard how cost-conscious employers attempting to improve their bottom-line restructure health-benefit options, add cost-sharing provisions, eliminate dependent coverage for employees, or fail to provide coverage at all for the increasing number of individuals employed in the low-paying service sector, the fastest-growing portion of our labor force. Indeed, many small employers cannot purchase health insurance at affordable prices. Thus employers are contributing to an increase in the number of uninsured indivudials as well as underinsured individuals.

Increasing numbers of working, tax-paying Americans have no health insurance coverage for themselves and their loved ones, and yet they lack access to Medicaid, society's medical safety net. As a physician, I am concerned about the human impact of the following observations:

First, we know that individuals without insurance use much less health care, even when they need it. Uninsured individuals who consider themselves in fair to poor health use 25 percent fewer ambulatory care visits; uninsured and underinsured individuals delay in seeking care for treatable medical conditions early in the course of their illness, or for preventive services which are known to be of specific benefit for medical problems.

Uninsured individuals are frequently denied access to physicians and medical facilities. Preventive services for kids, for example immunizations, are not provided. This in turn can lead to needless

disability as well as a delay in school entry if the child is unimmunized.

Pregnant women do not receive prenatal care and too often preterm infants, costly to care for, are born. And there are others.

Mr. Chairman, you have proposed a solution. The legislation under consideration today extends health care coverage to millions of currently uninsured children, and extends to countless other children whose families are already insured by employer-based plans certain coverage children uniquely need—well-baby care, immunizations, preventive services. Children are not uninsured or under-insured by choice. Many reside in working families who would purchase insurance if available through their employers. It is good and just social policy to assure that private health insurance coverage for medically appropriate and cost-effective services is available to families of working individuals.

Mr. Chairman, because of their tax-deductible status, employer-provided group health plans have become the dominant method of financing personal health services. We believe government's power to regulate, and to create financial incentives for business can make private health insurance accessible to more people.

Insurance companies discriminate against kids by denying coverage to children for services they need and they use—ambulatory and preventive services. Children are hospitalized with one-fourth the frequency of adults, yet use two and a half times the frequency of ambulatory services, particularly when they are young. Children's health expenses are low, about $500 per capita per year, compared to almost $1,500 per capita for individuals age 45 to 64. The total premium costs of insuring a child's health supervision to age 20 is minimal, about the cost of one day in a children's hospital, and is cost effective. We therefore applaud its inclusion in this bill.

Mr. Chairman, it is ironic that Medicaid provides for Early and Periodic Screening, Diagnosis and Treatment of eligible children, but private health insurance does not. Yet the House Select Committee has concluded in its report that EPSDT saves two dollars for every dollar invested in the program. Children insured under Medicaid utilize preventive services one-third more than their privately insured low-income counterparts. This is not just. What kind of incentives must we have to encourage individuals to work and to get off the welfare rolls?

Mr. Chairman, having praised certain provisions in this legislation, we must share serious concern about less sanguine aspects of it. The proposal is not ideal; its lack of comprehensiveness is particularly disturbing, inasmuch as this legislation, if enacted, preempts the rights of States to impose its own required services on insurance plans, precluding possibly more progressive benefits. The Academy will also have some suggestions about the catastrophic proposal and regional pools for small employers at a later date.

In summary, Mr. Chairman, we seek equity and justice in Federal policy for children and their families through regulation of employer-based health insurance plans. We believe all children have a right to receive quality and comprehensive health care. The medically indigent child has a particular need for ambulatory and preventive services. To paraphrase Professor Uwe Reinhardt, of

Princeton University, "let us not lose the right to consider ourselves citizens of a civilized nation. Let us, as a concerned society, enable people to care for one another without the government having to do it."

This bill encourages private solutions to public problems. The Academy is eager to work with your Committee to solve these pressing problems and to fashion fair, comprehensive health care coverage for millions of America's children.

Thank you.

[The prepared statement of Dr. Aronson follows:]

American Academy of Pediatrics

T E S T I M O N Y

BEFORE THE

UNITED STATES SENATE

LABOR AND HUMAN RESOURCES COMMITTEE

ON

THE MINIMUM HEALTH BENEFITS FOR AMERICAN WORKERS ACT OF 1987

BY

JEROLD ARONSON, M.D., F.A.A.P.

May 19, 1987

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Mr. Chairman, members of the committee, I am Dr. Jerold Aronson, a practicing pediatrician from Narberth, Pennsylvania, near Philadelphia. It is a great honor to appear here this morning on behalf of the American Academy of Pediatrics to speak in support of important maternal and child health provisions included in the Minimum Health Benefits for American Workers Act of 1987. This is my first opportunity ever to testify before members of Congress, and I have to say that it is on an issue that couldn't be closer to my heart or to the hearts of my colleagues.

POPULATION IN NEED

As reliably reported just two months ago, in the United States in 1985 there were approximately 35 million uninsured individuals of whom:

- 55 percent were employed workers (19 million).
- 32 percent (11 million) were children age 18 or under.
- 13 percent were non-working adults.

Of the uninsured children, 64 percent (7 million) lived in a family headed by someone who was also uninsured while 29 percent (3.2 million) lived in a family with employer-based insurance coverage.

National Medical Care Utilization and Expenditure Survey (NMCUES) data from 1980 suggests that an additional 7 million children are only insured for part of the year. Thus, while children represent only 29 percent of the population, they represent at times almost half of the uninsured. These data concern us as pediatricians because the lack of insurance is denying access to medically necessary care, including preventive services recommended by public health

agencies for many children. Additionally a disproportionate number of the 10 percent of children with at least one chronic disability, or the 3 percent of children who are severely handicapped, are among the working poor and may be unable to obtain needed medical care.

TRENDS

Existing data are distressing enough -- but the trends are even worse. One might suppose from the large number of television advertisements enticing us to join this or that health plan that Americans are well insured and healthy. Hardly. The United Hospital Fund of New York (December 1986) cites a 23-percent increase in the number of New York State residents without health insurance coverage from 1980 to 1984. Since the number of people covered by Medicaid remained relatively constant during this period, the growth in the number of uninsured occurred entirely as a result of reductions in the numbers of individuals covered by private health insurance, despite that fact that the great majority of the uninsured were employed, or were members of households with at least one wage earner.

Cost-conscious employers attempting to decrease expenses and improve their "bottom line" create cheaper, restructured health-benefit options, add cost-sharing provisions, eliminate dependent coverage for employees, or fail to provide coverage at all for the increasing number of individuals employed in the low-paying service sector, the fastest growing portion of our labor force. Very small employers, even if desirous of providing health insurance coverage for their employees, find that they cannot because it may not be affordable. Thus, employers eager to reduce their burgeoning health insurance expenditures are contributing to an increase in the uninsured as well as the underinsured since

increasing co-payments and co-insurances may encourage lower-paid workers to drop dependent coverage altogether.

THE HUMAN IMPACT OF LACK OF HEALTH INSURANCE

Increasing numbers of working, tax-paying Americans have no health insurance coverage for themselves and their loved ones, yet they lack access to Medicaid, society's medical safety net. Consider the human impact of the following observations:

- First, individuals without insurance use far fewer health services, even when they need them. Of New Yorkers perceived to be in fair or poor health (1980), uninsured individuals had 25-percent fewer ambulatory care visits than insured individuals.

- Rand Corporation data indicate that uninsured and underinsured individuals delay in seeking 1) care for treatable medical problems early in the course of the illness, and 2) preventive services known to be of benefit for specific medical conditions.

- Uninsured individuals are denied access to physicians and medical facilities.

- Preventive services for children (e.g., immunizations) are not provided in accordance with AAP and Public Health Service guidelines, resulting in increasing numbers of cases of preventable childhood diseases such as measles and pertussis. This, in turn, leads to needless disabilities as well as delays in school entry because children are unimmunized.

- Pregnant women fail to receive prenatal care; too often pre-term infants are born, and they are costly to care for.

- Children whose vision defects are not detected early don't learn to read.

- Those whose anemia remains undetected don't pay adequate attention in school.

- The unimmunized may die.

ARE THERE SOLUTIONS?

The legislation under consideration today would extend health care coverage to millions of currently uninsured children -- and it would extend to countless other children whose families are already insured by employer-based plans certain coverage children uniquely need, i.e., well-baby care, including immunizations; and preventive services for children through age 18, and prenatal care for pregnant women.

As you may know, Senator John Chafee of Rhode Island and Representative Ed Jenkins of Georgia have for several years sought to promote equitable preventive health care coverage for children in group health plans by way of the federal tax code (S. 968, H.R. 1449, respectively). They, and the Academy, are delighted that in this legislation you focus still sharper attention on children's needs, which have been long ignored. Children are not uninsured and underinsured by choice -- many reside in working families who would purchase insurance if available through their employers. It is good and just social policy to assure that private health insurance coverage for medically appropriate and cost-effective services is available to families of working individuals.

Mr. Chairman, because of their tax-deductible status, employer-provided group health plans have become the dominant method of financing personal health

services in the United States. We believe that government's power to regulate, and to create financial incentives for business can make private insurance more accessible and appropriate for all. According to the Bureau of Labor Statistics, more than 80 percent of all full-time employees are covered by some form of private health insurance. Unfortunately, the structure of these indemnity insurance plans continues to encourage hospitalization, procedures and other acute services that contribute directly to escalating health care costs, while they discourage preventive and ambulatory care that can detect and treat medical problems early, potentially decreasing costs.

Insurance companies discriminate against children by denying coverage to children for services they need and use, e.g., ambulatory and preventive services. Children are hospitalized with 1/4 the frequency of adults, yet use 2.5 times the ambulatory services, particularly when they are young. Children's health expenses are low, approximately $ 500 per capita per year (under 17 years) compared with $ 1,485 per capita per year (age 45-64 years). Yet many working families with children have high out-of-pocket expenses due to the absence of insurance coverage for basic child health services. The cost of providing children's health supervision coverage is minimal and is cost-effective; we applaud its inclusion in this bill.

Mr. Chairman, it is ironic that Medicaid provides for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) of eligible children, but private health insurance does not. It has been found that children screened through EPSDT in Missouri were on average 33-percent less costly to Medicaid than other children; in Ohio 30-percent less costly; in North Dakota 40-percent less and so forth. The House Select Committee concluded in its report that EPSDT saves $2 for every dollar invested in the program. The total cost for providing all child

health supervision services (including prenatal care for adolescents) from birth to age 20 is less than the cost of one day in a hospital. No fewer that 15 studies have found that preventive health care for children has a clear, positive effect on reducing illness and improving children's health.

NMCUES data indicate that young, privately insured low-income children are 1/3 less likely than their Medicaid-insured counterparts to utilize preventive services. Disabled low-income children with high out-of-pocket burdens may also be exposed to the danger of less remedial medical care than are their publicly insured counterparts. What kind of incentives do we want to encourage individuals to work and get off the welfare rolls?

ADDITIONAL CONCERNS

Having praised major maternal and child provisions in this legislation, the Academy with equal emphasis also must share its serious concern about less sanguine proposals. There remains an array of important services not covered here, including mental health services, drug and alcoholism treatment programs, rehabilitative services, prescription drugs, home care, etc. These limitations are particularly disturbing inasmuch as this legislation, if enacted, would preempt the right of states to impose their own required services on insurance plans, thereby precluding possibly more progressive benefits. Indeed, many of these services are currently covered by various state mandates. We also have questions about the structure of the catastrophic proposal and regional pools for small employers. The Academy will submit more detailed comments after vetting the measure as introduced.

SUMMARY

Mr. Chairman, we seek equity and justice in federal policy for children and their families through regulation of employer-based health insurance programs. We believe that all children have a right to receive quality and comprehensive health care. The medically indigent child has a particular need for ambulatory and preventive services. To paraphrase Professor Uwe Reinhardt of Princeton University, let us not lose the right to consider ourselves citizens of a civilized nation. Let us, as a concerned society, enable people to care for one another without the government having to do it. The Minimum Health Benefits for American Workers Act of 1987 encourages private solutions for public problems. The Academy is eager to work with your committee to solve these pressing problems and to fashion fair, comprehensive health care coverage for millions of America's children.

The CHAIRMAN. Thank you very much.

A point that was referenced in the testimony which perhaps we have not stressed enough is the importance of early intervention and how much money that saves. You know, we are going to be asked constantly about figures and costs. We never emphasize or stress enough the importance of the costs of anguish and heart ache and concern of parents for children, or loved ones for each other or for members of a family, or the general anxiety that citizens have because of the injustice that exists in failing to meet these very important, essential and basic human needs.

I think Dr. Aronson mentioned both the amounts of intervention that take place under Medicaid versus private insurance plans and also the figures in the House about two dollars being saved for every one that is expended. I would be interested, Mr. Owen and Sr. Wilhelm, if you could just talk about that as professional health care providers. Perhaps later on you can give some financial calculations, but if you could just talk about that and its importance, as people who have spent a good deal of time on this, so that we have in the record the fact that with early intervention, there is a good opportunity that we will be saving money.

Mr. OWEN. I would be happy to comment quickly, Senator, on two counts. One, I sat on the Southern Governors Task Force on Maternal Child Health, and it is absolutely correct that the dollars spent in prevention early on is worth two or three times what it will be later on in actually taking care of the patient.

The second thing of concern to us is hospitals do take care of the acutely ill patient, the automobile accident and somebody who is really sick. What is happening is that we do not see them until they are really quite ill and we are spending a lot more money at that point in time, where if intervention would occur early on—I think there have been some studies that show that people who are uninsured tend to die of cancer more often than those who are insured, and it is primarily because they are not getting that early detection. So there are some real good reasons why this kind of bill is most helpful.

Sr. Wilhelm, who works on this job every day of her life, probably has a lot more to add.

Sr. WILHELM. I only want to call attention to the three speakers that you had here earlier this morning who spoke so poignantly in terms of their own lives and the lives of their children. All of those mothers indicated that they had children with health problems and all were hesitant to achieve any treatment for those problems, and all of us from the health field know that illness does not become better of its own accord, it only becomes aggravated and then there are greater resources that are needed in the long run.

The CHAIRMAN. Let me just ask—I would be interested in your comments—am I correct that basically we are paying currently for inadequate coverage, one way or the other? We always think—this is just going to add other kinds of problems. Can you address that? Someone is paying for most of this. If you do not have the early intervention, people are going to get sicker and have to go to those hospitals, and you are going to have to either provide charity care, or someone else is going to have to pay for the care. Am I correct on that, one way or the other?

Mr. OWEN. That is absolutely correct. There is no such thing as free care, and I think you mentioned that earlier in the press conference. We have to pay nurses' salaries, we have to pay for the medicine and foods that we buy for those patients, the resources that go into the acutely ill patient are greater than, if we caught the patient at an earlier stage in their illness.

There are two ways of paying for it. One is passing it on to those who can pay, which is a shift in the way we obtain our revenues, or being able to raise the money through charity drives and other forms that the nonprofit hospital system has, but that is extremely difficult. So we are caught in the bind of having to provide health care to the acutely ill, but at the same time not having the resources to pay for it.

Dr. ARONSON. Mr. Chairman, we can talk about cost shifting, the point that you raised about who is paying the bill, but the individuals who are truly paying the bill are the children and the adults who are in pain, whose disabilities, and functional impairments are not getting corrected at a point in time when they can become competitive citizens of our country and contribute in a productive way to our society. While we are talking about dollars and cents, Mr. Chairman, you eloquently brought up the fact that individuals who have handicapping conditions, who have medical problems are the ones who are truly paying the costs of their being uninsured.

The CHAIRMAN. Very good.

Sr. WILHELM. Not only in dollars, but in hours, days, months spent in suffering, human suffering which I feel that we have an obligation to respond to.

The CHAIRMAN. Very good. It is excellent testimony—you each raised some good points and we will be glad to work with you on some of those.

I want to thank you very much.

Mr. OWEN. Thank you.

Sr. WILHELM. Thank you very much.

Dr. ARONSON. Thank you very much.

The CHAIRMAN. Our next panel is Karen Davis, who is Professor and Chairman, Department of Health Policy and Management, Johns Hopkins University; and Gail Wilensky, who is Vice President, Division of Health Care, Project HOPE.

Ms. Davis, we welcome you back to this Committee. Karen Davis has had a very distinguished career in health policy for a number of years and has appeared before our Committee on a number of different occasions on health legislation. We look forward to your testimony here today.

STATEMENT OF KAREN DAVIS, CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH; AND GAIL WILENSKY, VICE PRESIDENT, DIVISION OF HEALTH CARE, PROJECT HOPE

Ms. DAVIS. Thank you, Mr. Chairman, for the opportunity to testify on the absence of health insurance coverage among certain segments of the employed population. As the cost of health care has risen sharply over the last decade, even workers with moderate in-

comes can face devastating medical care bills unless they are protected by health insurance.

Particularly alarming is the fact that access to health care in this Nation is becoming worse, not better, and the ranks of the uninsured are swelling.

Today, I would like to share with the Committee the latest data on trends in gaps in health insurance coverage, what we know about the consequences of these gaps in coverage, and suggest ways in which gaps in health insurance coverage could be closed.

As we have heard today, many Americans face a serious problem, the absence of even minimally essentially basic health insurance coverage. In 1986, 37 million Americans, or about 17.6 percent of the non-elderly population, did not have any health insurance coverage. Particularly disturbing is the fact that the ranks of the uninsured are growing. In 1980, 30 million Americans, or about 15 percent of the non-elderly population, did not have health insurance coverage. Today, there are about 7 million more people without health insurance coverage than was the case six years ago.

For those with coverage, most people obtain it through their employers. About two-thirds of the non-elderly population have employer-provided health insurance coverage. Another 12 percent are covered by Medicaid or other public programs, and about 8 percent purchase private health insurance coverage individually, leaving 37 million uninsured.

Over half of the uninsured, about 20 million people, are in families where at least one member has a full-time job working 35 hours or more per week. Seventy percent of all the uninsured are in families where at least one member works at least 10 or more hours a week.

One-third of the uninsured are children, and most have very modest incomes. About a third have incomes below the poverty level, and only 20 percent have incomes greater than three times the poverty level.

Despite the impression that Medicaid covers the poor, in fact Medicaid covers less than 40 percent of the poor because many States have low-income eligibility standards and categorical restrictions restrict that program largely to one-parent families.

Gaps in employer-provided health insurance coverage occurs because such coverage is optional with employers. It is particularly low amongst smaller firms, in certain industries, such as agriculture, construction, retail trade, and services, and coverage is lower in the South and West.

So to a considerable extent, health insurance coverage in this country is a matter of luck. It depends on where you work and where you live. We are less clearly about why the number of uninsured is rising. When they first began to go up in the 1980s, it was assumed that that was a reflection of rising unemployment and the recession in 1982 and 1983. Yet, with improving economic conditions and declining unemployment, the numbers of uninsured have not declined but have continued to go up. There are several reasons why uninsurance may be increasing—the growth of jobs in the service sector, the growth of jobs in smaller firms, the growth of part-time jobs, the decline in Medicaid eligibility, the increasing tendency for employers to have employees pay part of the premi-

ums, particularly the premiums for dependents, and the growth in one-parent families which are less likely to have coverage than two-earner families.

While we need more analysis and research to sort out the causes, it is clear that gaps in employer-provided health insurance are responsible for a large portion of the uninsured population.

Sr. Mary Eileen Wilhelm mentioned the new report by the Robert Wood Johnson Foundation, citing evidence on deterioration in access to health care in the 1980s. In 1986, 13.5 million people reported not receiving medical care for financial reasons. An estimated one million individuals actually tried to obtain needed care but were turned away. Progress in improving access to care, particularly for poor and minorities, is clearly being reversed in the 1980s.

This survey had particularly disturbing evidence for the uninsured. They report that the uninsured are about 33 percent more likely to be in fair or poor health, but they receive 27 percent fewer physician services and are hospitalized 19 percent less frequently. One-fifth of the uninsured with chronic illness did not see a physician during the year.

I found it particularly troubling that fully two-thirds of the uninsured with serious symptoms—we are talking about bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet—did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. One-fifth of the uninsured with hypertension did not receive a blood pressure check during the year.

Clearly, absence of health insurance coverage is not only a serious financial problem, as we heard today, it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

It is urgent that action be taken to provide at least some minimal essential health insurance coverage for all Americans. I would like to applaud you and your cosponsors for the bill you introduced to mandate coverage from employers.

I think this also needs to be combined with improvements in the Medicaid program, to pick up those who would not be assisted by improved coverage in the workplace.

The provisions of a minimal essential health plan should be modest to keep premiums affordable, and your bill does a nice job of balancing the desire to keep premiums low with a desire to have minimally adequate coverage. It assures that employers will cover workers and their dependents, it mandates that employers pick up a minimum proportion of the premium, has provisions with regards to extending coverage for a period of time once people are unemployed, and has a minimum benefits package, including the basic services, and I think it is particularly important that preventive care, such as prenatal, delivery, and total infant care be comprehensively covered.

It sets a maximum ceiling on out-of-pocket liability and maximums on deductibles and coinsurance, and provides for choices of qualified health maintenance organizations.

There is one additional feature that I would like to suggest for your consideration, and that deals with the problems of low-wage

or small firms. Since private health insurance coverage can have very high administrative costs, in addition to some of the things you have considered you might want to consider letting such employers purchase Medicaid coverage for their workers.

Some of the welfare reform proposals, for example, would extend Medicaid coverage for 9 months or so once someone left AFDC and entered the workforce. For firms that are hiring a lot of low-wage workers, an option might be for that firm to simply continue their Medicaid coverage and picking up an actuarially equivalent premium, that might be an option to consider.

The primary criticism, as you know, raised against any type of mandated employer plan is that it would result in a loss of jobs for low-wage workers; the evidence on this is mixed. There well might be some small effects of increasing, for example, employer costs, by 10 percent, resulting in a 1 percent decline in employment.

Despite that, I think it is important to do this. We have seen the problems that people face who do not have the health insurance, so it is clearly a very important problem for them, with a very small potential effect on employment.

The plan that you have proposed does not constitute an excessively burdensome plan. It is a fairly low cost on an hourly basis. Another point to keep in mind is that the labor market for entry level workers is starting to tighten. We had a drop in fertility in the mid-1960s. There are fewer young people now entering the labor force. Employers are finding it more difficult to hire or find such workers, and I think under those circumstances any possible loss in employment is certainly minimized.

In addition, there has been no increase in the minimum wage since 1981, so there has been a decline in the cost of these workers to employers. And the types of jobs affected are largely the service sector, retail trade, where you do not have effects with international competition.

As you know, covering such people would drop the number of uninsured from 37 million down to around 15 million, and it is this small final group that I think would need to be addressed through improved public coverage under the Medicaid program. If you were to cover all the remaining people below the poverty level under Medicaid, you would pick up another 7 million of the uninsured; if you let people between the poverty level and twice the poverty level purchase Medicaid individually on a sliding scale premium, you could pick up another 3 million, and then you would reduce the uninsured down to 5 million who could purchase Medicaid by paying an actuarially fair premium. Those would be people with incomes about twice the poverty level.

In sum, such a public-private partnership approach would be both economically and administratively feasible to remedying the gaps in health insurance coverage that threaten the health and well-being of a significant portion of our Nation's population. While the specific details could be modified, or even more modest steps taken on an incremental basis to close these gaps, this plan proposed should be carefully considered and debated.

I congratulate you and the Committee for undertaking serious examination of ways in which such gaps in coverage can be eliminated.

Thank you.
[The prepared statement of Ms. Davis follows:]

EMPLOYMENT AND HEALTH INSURANCE COVERAGE

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on the absence of health insurance coverage among certain segments of the employed population. As the cost of health care has risen sharply over the last decade, even workers with moderate incomes can face devastating medical care bills unless they are protected by health insurance. Fortunately, about 85 percent of all workers and their families receive such health insurance from their employers. For a significant minority, however, gaps in employer-provided health insurance pose significant barriers to needed medical care and undermine the health and economic security of families struggling to earn a livelihood. Particularly alarming is the fact that access to health care in this nation is becoming worse not better and the ranks of the uninsured are swelling.

Today, I would like to share with the Committee the latest data on trends in gaps in health insurance coverage, what we know about the consequences of these gaps in coverage, and suggest ways in which gaps in health insurance coverage could be closed.

Employment and the Uninsured

With passage of the Medicare program in 1965, virtually all elderly Americans were assured of at least some health

insurance coverage. Attention this year has focused on the inadequacy of this coverage and the need for improvements in protection against catastrophic health expenses. Improvement in Medicare coverage is important and should particularly benefit those elderly Americans with modest incomes who can not afford to purchase supplementary coverage.

However, many of the nonelderly face a far more serious problem -- the absence of even minimally essential basic health insurance coverage. In 1986 37 million Americans, or about 17.6 percent of the nonelderly population, did not have any health insurance coverage.

Particularly disturbing is the fact that the ranks of the uninsured are growing. In 1980, 30 million Americans, or 15 percent of the nonelderly population, did not have health insurance coverage. Today there are 7 million more Americans without health insurance coverage than was the case six years ago.

People under age 65 obtain health insurance coverage in three ways: they receive group health insurance provided by their employer, they purchase health insurance individually from private health insurance companies, or they qualify for coverage under the Medicaid program.

Coverage under an employer health plan is the most common way in which the nonelderly obtain health insurance coverage. About 132 million of the 209 million nonelderly population, or about two-thirds, have employer-provided

health insurance coverage. About 24 million are covered by Medicaid or other public programs. About 16 million purchase private health insurance coverage individually, leaving 37 million uninsured.

The common impression is that the uninsured are outside the work force -- mostly young adults who have not yet found jobs. This is not the case. Surprisingly, over half of the uninsured, 19.6 million people, are in families where at least one member has a full-time job working 35 or more hours per week. Seventy percent of all the uninsured are in families where at least one member works at least 10 or more hours per week. The remaining 30 percent are unemployed or out of the labor force.

About one-third of the uninsured are children under age 18. Sixteen percent of the uninsured are between the ages of 45 and 65. The remaining half of the uninsured are between the ages of 17 and 45.

Another common impression is that Medicaid covers all of the poor. In fact Medicaid covers less than 40 percent of the poor. Absence of Medicaid coverage among the poor occurs because states set income eligibility levels well below the federal poverty level and because categorical restrictions limit coverage largely to one-parent families -- excluding two parent poor families, childless couples, and single individuals.

Nearly all of the uninsured have modest incomes. About

one-third have incomes below the poverty level. Only 20 percent have incomes greater than three times the poverty level. Individual purchase of private health insurance is not economically feasible for most of the uninsured. Individual plans typically have inadequate benefits and charge premiums well in excess of actual benefit outlays.

Gaps in employer-provided health insurance coverage occur because such coverage is optional for employers. About half of all employed uninsured persons work in firms with fewer than 25 employees. Employer-provided health insurance coverage is particularly low in certain industries--including agriculture, construction, retail trade, and services. Coverage of workers is lower in the South and West than in the North and Central regions of the country.

To a considerable extent health insurance coverage in this country is a matter of luck. Those fortunate enough to be employed by large, unionized, manufacturing firms are also likely to be fortunate enough to have good health insurance coverage. Those who have modest incomes, live in the South and West or in rural areas, and those who are black or minority group members are more likely to bear the personal and economic effects of lack of insurance and the consequent financial barriers to health care.

While the patchwork private-public system of financing health care in the U.S. explains why a significant part of population does not have health insurance coverage, it is

less clear why the number of uninsured is rising. When the first evidence on growth in the uninsured population in the early 1980s became available, it was assumed that this was in large part a reflection of the deep recession of 1982-1983 and rising unemployment. Yet, with improving economic conditions in 1985 and 1986, the numbers of uninsured have not declined, but have continued to rise slightly from 35 million in 1984 to 37 million in 1986.

Several reasons have been advanced to explain the growth in uninsured:

- The growth of jobs in the service sector which tend not to have health insurance coverage.
- The growth of jobs in smaller firms.
- The decline in Medicaid eligiblity.
- The increasing tendency for employers to require employee contributions to health insurance premiums, including paying the full cost of dependent coverage.
- The growth in one-parent families, which are less likely to have health insurance coverage than two-worker families.

While considerable further analysis and research will be required to sort out the independent contribution of these and other factors, it is clear that gaps in employer-provided health insurance are responsible for a large portion of the uninsured population.

The Uninsured and Access to Health Care

A new report on access to health care in 1986 recently released by the Robert Wood Johnson Foundation contains evidence on the deterioration in access to health care in the 1980s. Thirteen and one-half million people reported not receiving medical care for financial reasons. An estimated one million individuals actually tried to obtain needed care but did were turned away. Several indicators suggest that progress in improving access to health care for the poor and minorities has been reversed between 1982 and 1986.

The Robert Wood Johnson Foundation access survey found particular problems for the uninsured. The uninsured are one-third more likely to be in fair or poor health than the nonelderly insured. Yet despite their poorer health status, the uninsured receive 27 percent fewer physician services and are hospitalized 19 percent less frequently than the insured. One-fifth of the uninsured with chronic illness did not see a physician during the year. Fully two-thirds of the uninsured with serious symptoms (e.g. bleeding, loss of consciousness, chest pain, shortness of breath, weight loss unrelated to diet) did not see or contact a physician. One-fifth of uninsured pregnant women did not receive care in the first trimester of pregnancy. Twenty-two percent of the uninsured with hypertension did not receive a blood pressure check in the year.

Clearly, absence of health insurance coverage is not

only a serious financial problem it is a health problem as well. Millions of Americans are at risk of death and disability because of an inability to pay for needed health care.

Policy Action to Improve Health Insurance Coverage

It is urgent that action be taken to provide at least some minimal essential health insurance coverage for all Americans. I would like to propose a partnership between the public and private sectors to begin to close the gap in coverage. This proposal has two major components:

- Mandating a minimum health insurance plan to be provided by employers to full-time workers and their dependents; and
- Residual coverage under Medicaid available to everyone falling outside employer plans on a sliding-scale premium contribution basis.

Employer Mandate

Provisions of a minimal essential health plan should be kept modest to keep premiums affordable. Improvements can be made over time as economic conditions permit. Such a minimal plan might include:

- Coverage of workers working 25 hours or more per week and their dependents.
- Employer contribution of at least 75 percent of premiums.
- Extension of coverage for 90 days following

termination of employment with employers continuing to pay their share of the premium.

- Minimum benefit package including inpatient hospital services, physician and other ambulatory services, preventive care including complete prenatal, delivery, and total infant care without cost-sharing, home health care, and limited mental health care.
- Maximum cost-sharing per family of $2,500 or $1,250 for an individual. Maximum deductibles of $500 and coinsurance of 25 percent.
- Choice of federally qualified HMOs and PPOs where available.
- Option for small firms or low wage firms to purchase Medicaid coverage for workers and dependents with a 50 percent employer and 50 percent employee contribution (given the more comprehensive Medicaid benefit package).

The specifics of such a package could be altered balancing the desire to have minimally adequate coverage with the desire to keep the premium low.

The primary criticism raised against such a proposal is that it would be an economic burden on low-wage firms and might result in loss of jobs for low-wage workers. There is some evidence that suggests a 10 percent increase in labor costs might result in a one percent decline in employment.

Despite this possibility, I support mandating a minimal employer plan. First, the plan outlined does not constitute an excessively burdensome plan. It is estimated that a modest package could be provided for $0.50 to $0.60 per hour. Second, the labor market for entry-level workers is tightening with the drop in fertility in the mid-1960s leading to a smaller size cohort entering the labor force. Loss of jobs in such an environment is less likely. Third, the minimum wage has not been increased since 1981, so that the cost of entry-level workers has declined in real terms over the last six years. Fourth, the types of jobs that are potentially affected are largely in the service sector or retail trade which are not as sensitive to international competition.

Coverage of employers and dependents under this plan would add 22 million more people to health insurance coverage, and drop the number of uninsured from 37 million to about 15 million.

Medicaid Coverage

Under this proposal, the Medicaid program would be expanded to provide acute health care benefits to the entire population falling outside employer mandated coverage and Medicare coverage. It would provide complete coverage to all poor and premium-financed coverage to others. Medicaid would be a secondary payer for individuals covered under employer plans or Medicare.

The provisions of this component include:

- o Automatic coverage of all individuals under the poverty level.
- o Optional purchase of Medicaid to all nonpoor not covered under an employer plan on a sliding scale premium basis.
- o The Medicaid program would cover the current mandatory benefits plus prescription durgs, without arbitrary limits on amount, duration, or scope of benefits. For individuals purchasing coverage with a sliding-scale premium, modest cost-sharing provisions could be included.

Of the 15 million individuals left uninsured by the employer mandated coverage, 7 million individuals with incomes below the federal poverty level would be newly covered by Medicaid. Another 3 million individuals with incomes between the poverty level and twice the poverty level would be eligible to purchase Medicaid coverage on a subsidized basis. About 5 million remaining uninsured with incomes above twice the poverty level could purchase Medicaid by paying the full actuarially fair premium.

Summary

The private-public partnership set forth here is an economically and administratively feasible approach to remedying the gaps in health insurance coverage that threaten the health and well-being of a significant portion of our

nation's population. While the specific details could be modified, or even more modest steps taken incrementally to close these gaps in coverage, the plan proposed here should be carefully considered and debated. I congratulate the Committee for undertaking serious examination of ways in which such gaps in coverage can be eliminated. Thank you.

The CHAIRMAN. Very good. We will get back to you with some questions.

I will now call on Dr. Gail Wilensky, who is Director of the Center for Health Care of Project HOPE, well known to students of health policy, and one of the leading authorities on the characteristics of the uninsured. We look forward to hearing your testimony.

Ms. WILENSKY. Thank you, Mr. Chairman. Thank you for inviting me to testify before your Committee.

As you have indicated, my name is Gail Wilensky and I am Vice President of Health Affairs at Project HOPE. I am here, however, as an independent health policy analyst and not as a representative of Project HOPE.

The purpose of my presentation is to discuss some strategies to resolve the problems of the employee uninsured, including some raised by the minimum essential health care proposal.

The 1980s are regarded as a time when market elements and competitive prices have become an accepted and welcome part of the landscape of the U.S. health care systems. Employers have redesigned the health plans offered their employees, introducing utilization review programs encouraging alternative delivery systems, and adopting various other strategies to obtain a value for their health care dollar.

The Federal Government has also adopted strategies to try to lower the costs of health care coverage. While those who insured are likely to be made better off as a result of these changes, those who are uninsured will be placed at an increased risk of having services cut off from them and being shut out of the health care systems as providers feel more pressure to compete for the paying patient.

These pressures have led to questions about the limits of private insurance and the need for increased governmental programs, including mandating insurance. There are, to be sure, compelling reasons to expect that more public sector dollars will have to be spent. We need to use public funds to change the Medicaid system that allows some States to set a cutoff level at 25 percent of the poverty line, and that excludes many people, no matter how low their income, because of their family unemployment status. Other public sector dollars are needed to help subsidize risk pools for the uninsurables and to provide places of care of last resort.

The more difficult question to answer is whether our system of private insurance for the employed population can remain voluntary based on incentives, primarily tax incentives, or whether we will need to impose a mandated system based on regulation.

The United States already provides strong incentives to obtain employer provided insurance by excluding employer provided contributions from the employee's taxable income. This system has provided insurance for the vast majority of our working population. Similar incentives could and should be extended to the self-employed and sole proprietors, and assistance more than we offer now can be offered to small employers who wish to engage in pooling arrangements such as multiple employer trusts and the equivalent of a Taft-Hartley trust for non-unionized workers to help the employer with high labor turnover.

Some say that these strategies have already been tried and found wanting, but in fact there are few instances of communities or employer groups creating solutions either for the large numbers of employee uninsured or for the medically uninsurable. Although the latter represent a very small proportion of the population, problems of adverse selection have been the Achilles heel of industry pooling arrangements and the uninsurable risk pools may represent just the safety value needed for them to work.

If these purely tax incentive-based strategies are found to be insufficient, some form of subsidization could be offered to small employers and to employers of low-wage workers, either by directly subsidizing the employer or, more likely, by establishing some sort of subsidized risk pool. This type of subsidization has some problems in that it may disrupt the market already for small employers, since most small employers offer health insurance already and many low-income workers already have private insurance and they also will, of course, want the subsidy.

Whether or not we can target a subsidy to only those who do not now offer health insurance is unclear. The Robert Wood Johnson Foundation is currently funding a number of demonstrations to try to see what can happen in this area, sometimes using——

The CHAIRMAN. Do you mean if "X" small business provides health insurance and "Y" does not across the street, then you are suggesting that the Federal Government subsidize the one that is not providing insurance? Is that what you are saying?

Ms. WILENSKY. I am saying——

The CHAIRMAN. This company is providing insurance and this other one is not. They are both making widgets. Do I understand you to say that we ought to take American taxpayers' money and subsidize the one that is not doing it?

Ms. WILENSKY. I think right now we are having some pools that are offered in States where employers, small employers are able to provide for their very low-wage employees insurance that has the administrative costs covered by the State. There are some demonstrations going on right now funded by the Robert Wood Johnson Foundation to see whether or not that induces some of these small employers to in fact provide insurance for their low-cost workers.

The CHAIRMAN. Then you are not talking then about subsidizing the company, what you are doing is subsidizing some kind of a process by which smaller businesses, all small businesses, can buy health insurance at low cost?

Ms. WILENSKY. Correct. That is correct.

The CHAIRMAN. Thank you. Where are they providing it?

Ms. WILENSKY. They are in 14 States now. I can send you the information on these. Whether or not these experiments will in fact offer a mechanism for providing for inducing employers to offer health insurance to these low-wage workers or not is unclear. Most of these experiments are in their first year, they are three-year programs.

There is a concern that if they do work they may in fact induce some employers, small employers of low-wage workers who are now offering health insurance coverage to join their programs if it is made possible. That is a concern that is something that will remain to be seen during the course of these demonstrations.

There is no question that if these various strategies, either trying to help small employers form pools such as multiple employer trusts or set up Taft-Hartley trusts for their high labor turnover workers do not in fact provide means for offering health insurance to the worker, then indeed there will be strong pressures even more so to either offer mandatory insurance, to require mandatory insurance or to do some major restructuring of the system.

What would be the consequences of the mandatory program of employer provided insurance, it is obviously difficult to know for sure. It will depend in large part on the type of insurance that is required and the share of the premium that the employer is required to pay.

There is concern, as Karen Davis has already indicated, that if the employer is required to pay a substantial portion of the bill, say as much as 80 percent, that there may in fact be some loss of workers at the minimum wage level and that some of these individuals may be priced out of a job.

For workers whose jobs are not now threatened, consumers can expect to see some higher product prices. There is also some concern that firms, especially some of the newer marginal small firms, who cannot withstand the transition to higher consumer prices, or whose markets are very competitive, may have difficulties in surviving.

There is also the concern that mandatory insurance does not affect only those who do not offer health insurance, but because they require definitions of what constitutes insurance has the potential for affecting employers who also offer health insurance now.

Nonetheless, I think it is important to recognize that we must do something to help reduce the large numbers of uninsured people in the United States, especially the employed uninsured. Perhaps the concern of mandating insurance will be sufficient to push employer groups and communities into more creativity than they have shown in the past as is being demonstrated by the Robert Wood Johnson Foundation demonstrations.

We do need to recognize that if we do not do something to substantially reduce the number of uninsured, particularly uninsured workers, we should expect to see either mandatory insurance or some other major restructuring of our system.

Thank you.

[Article submitted by Ms. Wilensky follows:]

VIABLE STRATEGIES FOR DEALING WITH THE UNINSURED

by Gail R. Wilensky

Prologue: *One of the stunning realities of the indigent care problem facing the United States is that the majority of its victims are not on the public dole, but are employed workers and their dependents. Many of these people are employed by small businesses that offer a far more modest package of fringe benefits than the large American corporation. As the service industry has burgeoned, and with it the proliferation of more jobs requiring fewer skills, the number of uninsured workers has increased, too. In this essay, Gail Wilensky outlines strategies that could be pursued on behalf of reducing the number of uninsured people. There have always been a substantial number of people without health insurance. The estimated size of this population has increased from 25 million in the 1970s to more than 31 million today. As Wilensky points out, one of the major forces propelling this issue is the introduction of more competitive pressures in health care. She says: "As business and government continue to demand better value for their dollar, the uninsured can expect to find it increasingly difficult to gain access to the health care system." Wilensky, who has closely tracked indigent care issues for a number of years and developed a national reputation in the process, places the greatest emphasis in her paper on incremental strategies for pursuing the indigent care issue. This emphasis places in sharp relief the absence of political will that exists for considering the indigent care problem as a crisis calling for a bold and uniform national response. Wilensky received her doctorate in economics from the University of Michigan. She was instrumental in designing and implementing the National Medical Care Expenditure Survey while working (1975–1983) at the National Center for Health Services Research. Since 1983, she has been in charge of Project HOPE's domestic division and director of its Center for Health Affairs.*

The problem of providing medical care to individuals who lack insurance has become a staple of the health policy diet, but no ready solutions have emerged. Several truths seem apparent, though, for anyone who has wrestled with this question. There is no silver bullet that will somehow emerge as the answer to our policy dream. America's pluralistic health care system dictates that any solution must involve both the public and private sectors, and any answer will not be forever but rather the next chapter in an evolving saga of public policymaking.

The number of uninsured and their characteristics, the amount and distribution of uncompensated care and its consequences, and the nature of the problem in a competitive environment have been discussed innumerable times.[1] It is therefore sufficient to summarize these issues before considering strategies to deal with the uninsured.

The Problem

The United States has always had many individuals without health insurance. Most estimates indicate that there were about 25 million people uninsured at any point throughout much of the 1970s.[2] These were not, of course, always the same people—some were uninsured for only a few months, while others were uninsured for long periods. Since the end of that decade, the number of uninsured has increased at least moderately and maybe substantially, as has the amount of uncompensated care, most but not all of which is associated with the uninsured.

These increases, coupled with health care costs that have continued to rise faster than wages, profits, and government revenues, have exacerbated the present problem and led to an increased awareness about the issue. However, the fundamental reason the problem has worsened and the cause for the heightened concern is not the change in the numbers but the change in the financial environment of health care. This change has been characterized by the adoption, by all the major purchasers of health care, of a "prudent buyer" mentality—both in government and in the private sector. This mentality is hardly an unreasonable attitude for purchasers to adopt, but it has meant that the traditional way of financing care for the uninsured—by including the charges in the bills of private paying patients (the so-called cost shift)—is increasingly difficult. The movement away from cost-based reimbursement and the introduction of more competition into health care has meant that the problems of the uninsured that were more or less masked before the 1980s can no longer remain hidden. Nor is it just a problem of "who will pay." Research has shown that the uninsured systematically use less medical care than the insured population, and that they are less likely to seek care when sick. This means that as business and government continue to

demand better value for their dollar, the uninsured can expect to find it increasingly difficult to gain access to the health care system.

The number of uninsured in 1980 was only slightly higher than in the 1970s—about 26 million. There is some dispute about how much that number increased during the recession of the early 1980s. Estimates have ranged from 29 million to 34–35 million in 1983.[3]

There is greater discrepancy regarding the number after the recession. Two sources, the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP) reported that there were 34–35 million uninsured in 1983. In 1984, however, the CPS indicated that the number had increased to 37 million; SIPP meanwhile reported that the number had fallen to 31 million, a substantial decline though still higher than prerecession levels.[4] The lower estimate seems to make more sense given the 3 percent decline in the unemployment rate since the depths of the recession, even acknowledging the shift out of manufacturing and into service sectors. However, only additional data and further analysis will resolve this debate.

Despite the dispute about the absolute number of the uninsured, the characteristics of this population appear surprisingly stable from survey to survey: (1) About half of the uninsured are employed either full or part year; when their dependents are included, the employed uninsured account for 70 to 75 percent of the uninsured population; (2) While 35 to 40 percent were in families who are poor, at least one-third of the uninsured were in families whose income was twice the poverty line; and (3) Almost 90 percent of the employed uninsured worked for employers who did not offer health insurance.[5]

A question often raised is whether a market-oriented strategy can accomodate the poor. The answer seems to me to be clear—yes, but only if we recognize explicitly how health care for the poor is to be financed. What a market-oriented system cannot do is continue to finance implicitly, that is, by hidden subsidies, the care of the uninsured. This means that we cannot avoid decisions about how much we as a society are willing to spend on those who cannot finance their own health care and the circumstances under which they will receive their health care. Those who most support market-oriented reforms need to understand that clear decisions about how the uninsured will be cared for must be made if these reforms are to succeed.

Restructuring The System

Two basic strategies could be followed to cover the uninsured: completely restructuring the system or incremental "gap filling." The major advantage to restructuring is that a new system could be more rational than the one that has developed historically. In addition, it can provide

mechanisms to cover all of the poor and or uninsured. There is, of course, no guarantee that, just because we deliberately set out to redesign a system, the result will end up more rational or efficient than the system it replaced, though presumably we will have learned from previous mistakes. The obvious disadvantage is that a major restructuring is much more difficult to accomplish politically, since it threatens an existing power structure and must overcome current inertia.

When policy analysts speak of a new health care structure, most people think of national health insurance. Predicting major changes in political and economic systems is obviously very difficult, but, at least in the near future, national health insurance, at least as it exists in Great Britain or in Canada, does not seem likely. Nonetheless, the pressures being generated by the uninsured in a competitive environment, particularly if costs continue to increase at a rate twice as fast as the rest of the economy, will be very great. The possibility of national health insurance, particularly an American adaptation of the Canadian version, may therefore be regarded as an option for at least a segment of the electorate.

The Enthoven proposal. A strategy that has always seemed much more consistent with the American way of doing things—emphasizing competition, free enterprise, decentralization, and limited government—is the health plan advocated by Alain Enthoven.[6] The restructuring he envisions is that our current open-ended tax exclusion of all employer-provided health insurance coupled with a Medicaid program for a limited number of the poor be replaced by a system of vouchers for the poor and a refundable tax credit for the nonpoor, which would be applicable to the purchase of health insurance. The vouchers or tax credits could only be applied to policies that met certain minimum requirements. If the employer paid part of the cost of the premium, the employee could receive the credit from the government in the form of cash. Unlike most national health insurance systems, this approach allows for a variety of insurance plans suited to different tastes and permitting different forms of medical practice. Enthoven believes that prepaid group practice, because of the efficiencies it permits, will become the dominant form of practice, but that is a decision that would be made in the marketplace based upon consumer and provider preferences.

By introducing vouchers for the poor and tax credits for the nonpoor, which are not related to the specific job held at any point in time, a strategy such as the Enthoven plan would provide for explicit financing of all those currently uninsured. However, this plan has yet to be given serious consideration politically. Apparently a consensus still exists that the present system works well enough not to justify a complete restructuring to solve the problems of the 13 to 15 percent of the population who are currently disenfranchised. At the very least, there seems to be no consensus about what would be an acceptable replacement.

Incremental Strategies

The alternative to restructuring the system is developing a series of policies that are designed to "fill in the gaps" of our present structure of employment-based insurance for the working population and limited public programs for some of the nonworking population. Implementing such a policy requires an understanding of the uninsured population, particularly that most of the uninsured are neither poor (that is, below the poverty line) nor unemployed. There are at least three relevant groups to consider when devising policy strategies for the uninsured: the nonworking uninsured, the medically uninsurable, and the employed uninsured.

Group one: the nonworking uninsured. The group most of us think about when we think of the uninsured are the jobless, the very poor, and the chronically ill. Fortunately, they are not the majority of the uninsured. They do, however, represent at least 25 percent of the uninsured population, or some eight or nine million people. These people are the homeless, the deinstitutionalized mentally retarded, and the millions of people who, although poor, do not qualify for Medicaid because they are not "categorically eligible" or because they have income that is above the Medicaid cutoff level for their states.

The fundamental problem of our current Medicaid system is that eligibility is tied to the receipt of cash assistance and that each state can set the income limit wherever it deems appropriate and/or affordable. Additionally, cash assistance levels have not kept pace with inflation. Thus, Medicaid, which initially covered over 60 percent of the poor, now covers about 45 percent.[7] While some of the poor not covered by Medicaid have private insurance or at least Medicare, many are uninsured.

Although it is unlikely that Medicaid as it is now designed will ever be expanded to cover all of those below the poverty line, some expansion is necessary. Two of the most important changes needed are minimum federal standards for Medicaid income eligibility levels and cutting the link between categorical eligibility and the receipt of cash assistance. These two changes would mean that states such as Kentucky and Tennessee, which have Medicaid eligibility levels at 35 and 25 percent of the poverty line for a family of four, would have to raise their eligibility limits. And all of those falling below whatever lower limit is set should be eligible for Medicaid, irrespective of their family or employment status.

For individuals who are above the federal threshold or whatever level states choose above that threshold, a state should be able to institute an income-related buy-in program for Medicaid for which the federal government would pay part of the costs. This option would allow a transition phase between Medicaid, which provides extensive coverage,

and the completely unsubsidized coverage frequently available to those just above the Medicaid cutoff.

Both the expansion of Medicaid and the introduction of a Medicaid buy-in program are based on insurance principles rather than on a system of direct payment to providers. Wherever possible, this should be the preferred strategy. Nonetheless, for some populations—those who are difficult to reach or who have special needs, such as the homeless or the high-risk prenatal population—specially targeted programs directed toward providers who are trained and equipped to deal with these special populations may be more efficient and effective. And in the end, no matter how much progress we make toward filling in the gaps, grants to at least some providers will be needed to establish a place of care of last resort.

Financing care for the nonworking uninsured. How much all of these changes will cost and how they should be financed are obviously important issues. The cost of the Medicaid expansion will depend on the federally defined minimum level. If it were set at 50 to 60 percent of the poverty line, the states with large Medicaid populations such as New York, New Jersey, and California would not be affected, but many states in the South and Southwest would be. The higher the federal minimum, the larger the number of people affected. And breaking the link with the receipt of cash assistance would mean that substantial numbers of new people would be eligible for Medicaid even in states that have minimum levels above 50 or 60 percent of the poverty line.

Estimating the costs of the Medicaid expansion with any precision will be difficult because it will require information about the numbers of people on and off Medicaid at various income levels near the poverty line, by state, and that information is not available. Nonetheless, some approximate costs could be estimated, as they are whenever a Medicaid expansion is introduced. The increased Medicaid expenditures should retain joint financing by the federal and state governments. In general, Medicaid expenditures at both levels of government should be financed by general fund taxes, as they are now in almost all states. In states where additional general fund financing is regarded as politically impossible, some specific excise taxes could be used, but, in general, the more broadly based they are, the better.

The funds for targeting providers and the remaining indigent care pool should also be a combination of federal and state funds. Here the federal funds might be provided as an additional block grant with the amounts determined by some combination of infant mortality, homelessness, and unemployment rates. These federal funds could also be general fund revenues or the revenues generated by a cap on the amount of employer-provided insurance provided tax-free. The rationale for using the latter as a funding mechanism for indigent care is contained in

my earlier article on uncompensated care in *Health Affairs*.[4]

Funding at the state level should follow the general dictum of the more broadly based, the better. In this case, however, it may be possible to put together a series of specific excises to form a broader base than any one excise tax would represent. If hospital excise revenue were used, which seems to be a politically popular, although not otherwise very logical, base for a tax, it should be done with the clear intent of having it passed on to all insured patients as is done with a sales tax. If a premium tax is used, self-insured companies who are otherwise protected by the preemption clause of the Employment Retirement Income Security Act (ERISA) must be included. The optional use of an excise tax on employers who don't participate in a funding pool is a workable strategy that has been included in proposed legislation (S2403). If possible, funding by more general tax revenue such as income or sales tax is preferable.

Group two: the medically uninsurable. A small group of individuals, sometimes estimated at about 0.5 percent of the population, is unable to obtain insurance because of preexisting conditions. A strategy nine states have adopted is to establish an insurance pool for these individuals through which they can buy insurance, generally at a subsidized rate. This is an appropriate mechanism for dealing with this small but highly vulnerable population, although sometimes the existing programs have left these individuals with high deductibles and copayments or with high premiums because of the system's unwillingness to be explicit about subsidizing the insurance of this vulnerable group.

States have differed in how they set eligibility: some have required being turned down by one or two insurance companies or having a specified medical condition; at least one state, Connecticut, has defined eligibility in terms of a willingness to pay a high enough rate, such as 150 percent of a standard premium. This strategy also was included in the two access to care bills introduced last summer (HR4740 and S2403). While determining inability to obtain insurance in the private market is difficult, it is important in being able to offer subsidized insurance to low-income medically uninsurable people without risking interference with the private insurance market. The potential problem is not with the medically uninsurable, since there is no market for them, but rather with the low-income uninsured, for whom there is a market, albeit a difficult one for them to enter. This problem is explained further in the next section. As an alternative to using a sliding-scale premium, medically uninsurable people near the poverty line could be allowed into a Medicaid buy-in program.

Financing care for the medically uninsurable. A major question handled unsatisfactorily by most states is how to finance the subsidy associated with medically uninsurable people. Most states force the carriers writing insurance in their state to participate in the pool. The

losses are then partly financed by spreading them to the rest of the insured population (except that they are not spread to those who get their insurance from an employer who self-insures) and partly by forgiving part of the company's premium tax. This tax represents a back-door method of financing the subsidy through general funds. In general, the most appropriate way to finance the loss associated with the medically uninsurable is to use the broadest possible tax base. This could be a surtax on the income tax, a portion of a sales tax, or a value-added tax. It could also be financed by a specific excise tax such as a luxury tax or even a tax on restaurant meals. The financing of a Medicaid buy-in option has already been described.

A pool for medically uninsurable people will not directly affect many of the uninsured. However, it is likely to be an important part of any incentive-based strategy directed at the employed uninsured because it will remove an important element of risk for small employers.

Group three: the employed uninsured. Data indicate that approximately half of the uninsured, or about 15–17 million people, work at least some time during the year. These individuals and their dependents account for approximately 70 percent of the uninsured population. The employed uninsured tend to be low-wage, semieducated individuals working in small firms particularly in the agriculture and service sectors. The firms tend to have a disproportionate share of workers earning near minimum wage, although many are not minimum-wage workers.

Why such workers are uninsured is not entirely clear. Evidence from a survey by the National Federation of Independent Business, Inc., suggests that small firms may not provide insurance for a variety of reasons: premiums are too high, employee turnover is too great, the firm is not profitable enough, the firm cannot qualify for group rates, and many of their employees are secondary workers, covered under a spouse's policy.[9] Still, 65 percent of firms with fewer than 100 employees do offer health insurance to their employees as do at least 40 percent of firms with fewer than twenty-five employees. An effective strategy to address the problem of the employed uninsured should attempt to target those small firms that do not offer health insurance to their employees, while not disrupting the insurance for the vast majority of workers currently covered. This is not a trivial issue, since almost 70 percent of low-income workers already have private insurance and even 50 percent of the workers who are poor already have private insurance.[10]

There are a variety of ways to approach the problem of providing coverage to this group, including mandatory offering of health insurance by employers, mandatory funding of part of or all health insurance by employers, extending the full tax deduction of health insurance premiums to the self-employed, the use of subsidized risk pools, industry pooling mechanisms, and Medicaid buy-in arrangements for workers just

above the Medicaid eligibility level. The most basic decision is whether to use a mandatory strategy or an incentive-based strategy.

The most obvious way to ensure coverage is to mandate that employers offer health insurance to their employees. This could be entirely or primarily at the employer's expense, shared between employer and employee, or entirely at the employee's expense. The potential effects on employment and prices will vary substantially, according to the share that the employer is required to pay, the number of employees at the minimum wage, and technical conditions about the nature of production. In general, increasing the share that the employer must pay will increase the likelihood that at least some minimum-wage workers will be priced out of a job. For workers whose jobs are not threatened, consumers can expect to see higher product prices. Some firms, especially new and/or marginal small firms, which cannot withstand the transition to higher consumer prices or whose markets are very competitive, would probably not survive.

A minimally mandatory policy would require that employers only offer a health insurance package to their employees but not be required to finance it. The rationale for this type of mandate is that it would ensure that all employees have the opportunity to purchase insurance. Historically, almost all employees who have been offered health insurance purchase it, although usually the employer pays a substantial share. Whether a requirement to offer insurance would produce lower-cost insurance than is currently available is unclear.

Either type of mandated policy will require agreement on a minimum benefit package. In other words, once the offering or provision of health insurance is mandated, it is necessary to agree on the provisions needed to qualify a policy as being "acceptable" health insurance. This means that potentially many more firms could be affected than just those not currently offering health insurance.

The primary alternatives to mandatory insurance are incentives for employers to provide insurance coverage and/or for employees to purchase insurance. The challenge in devising such strategies is to adopt new incentives without disrupting existing patterns of health insurance. A potentially serious problem in creating new incentives is that their effect may be as strong on those employees already insured as on those employees not currently covered. The consequences of ignoring this problem may be to double or triple the costs of a program.

There are a number of ways to incorporate additional incentives into the system. One is to allow tax deductions for health insurance premiums for the self-employed and owners of unincorporated businesses, provided they extend similar coverage to their employees. Until this year, these individuals could not take such deductions. The recently enacted Tax Reform Act allows these persons to deduct 25 percent of

premiums for their own health insurance plans. The extent to which they will respond to this limited provision is unclear, both because it is so limited and because the provision is scheduled to end in three years.

The idea of using risk pools has already been discussed as an important strategy in providing insurance to the medically uninsurable. Risk pools could also be directed toward the general uninsured working population. The attraction of such an approach is that it might enable small employers to share the risk involved in providing health insurance; it could also provide a mechanism for subsidizing the purchase of insurance by certain employees.

There is some debate about whether and how risk pools for the employed uninsured would result in lower insurance prices than those available by other industry pooling mechanisms, aside from directly subsidizing the purchase of insurance. The primary reasons pooling mechanisms can lower costs is that marketing costs are lower and risks can be spread over a larger group, but many have argued that industry pooling mechanisms can do this as well as a state-sponsored risk pool. What industry pooling mechanisms cannot do is offer insurance at below market rates. While subsidized insurance pools should make it more likely that small employers not currently offering insurance would do so, they may also end up attracting many of the small employers who currently offer health insurance and other employers of low-wage workers as well. This could obviously make the cost of a risk pool much greater than it would appear from the numbers of employed uninsured.

Other incentive-based strategies that may help the employed uninsured without disrupting existing insurance coverage are those that rely on the formation of multiple employer trusts (METs) or other industry pooling arrangements. These types of pooling arrangements could lower the administrative costs of health benefits and ease the burden of the small employer. METs have been attempted in a number of communities although as yet only with modest amounts of success. One of the problems that METs have reported is adverse selection. This was reported to be a significant problem by the Council of Smaller Enterprises (COSE), one of the better known METs in the country. The existence of a risk pool for the medically uninsurable, which employers below a certain size could use to enroll their high-risk employees, and which unemployed or self-employed individuals could use as well, could alleviate the threat of adverse selection.

Another possible pooling strategy would involve the development of an administrative mechanism similar to the Taft-Hartley trusts to serve as the holder of insurance and thus assist small employers with high labor turnover. The Taft-Hartley trusts were developed for unionized workers in high labor turnover industries and act as the "holders" of the workers' health and welfare policies. Employers pay into the trust on the

basis of the number of hours employees work. Since the trust is the holder of the health and pension plans, the workers do not lose these plans as they move from job to job. A similar arrangement could be developed for nonunionized workers who change jobs frequently, thus making it easier for their employers to contribute and more likely to be attractive to the worker.

For uninsured workers who are below the poverty line but whose incomes are above the Medicaid cutoff levels, a strategy that should be given serious attention is the use of a sliding-scale, income-related premium that allows such workers to buy into Medicaid. This strategy provides health insurance to workers while reducing the disincentives whereby workers earning too much lose all Medicaid support. While some employers who currently provide insurance coverage to their below-poverty-line workers might discontinue their coverage to these workers or encourage them to apply for Medicaid, it should not be too serious a problem as long as the range of eligibility was limited and the subsidy declined rapidly.

How much would these various incentive-based strategies result in increased insurance to employees? It is hard to know in advance. Our experience is that almost all employees who are offered health insurance, even if they have to pay part of the cost directly out of pocket, purchase the insurance. Thus, if we can devise strategies that make it easier and cheaper for employers to offer health insurance, we may be able to substantially reduce the number of employed uninsured. But to the extent that some of the small employers do not offer health insurance because their low-wage employees would prefer to take all of their wages in cash or because several of their employees are covered by a spouse's insurance, the incentives discussed here will have little effect on increasing the coverage of uninsured workers. Should this be the case, we will be left with two alternatives short of a major restructuring of the system: either mandate employer-provided coverage or expect substantial numbers of workers to show up as "generators of uncompensated care," and pay selected providers to cover this function.

Financing care for the working uninsured. In general, the employed population finances its own insurance, as workers take part of their compensation in the form of health insurance. The tax exclusion associated with employment-related insurance means that part of the costs are also borne by a loss in general revenues, which means that part of the costs are subsidized by all of us through general fund taxes. Any strategies that increase the likelihood of small employers' offering health insurance will continue this mode of financing.

If, in addition to the existing strategies concerning employment-related insurance, special incentives are introduced such as subsidized risk pools or Medicaid buy-in programs for the poorest workers, these

additional subsidies would also have to be financed, and the previously stated dictum, "the more broadly based, the better," still applies.

Finally, if insurance were mandated, the financing would combine employee financing and general fund financing, as previously indicated; some financing would also come from consumers. The latter occurs because some of the costs of the mandated insurance would be borne by consumers in the form of higher product prices. In addition, there are a variety of implicit costs associated with this type of strategy, such as workers who would lose their jobs, small employers who would go out of business, and so forth. As with any program that is at least partly implicitly financed (such as our old cost-shifting strategy), it is difficult to know exactly who ultimately bears the full cost of this type of strategy.

The Limits Of Private Voluntary Insurance

The 1980s are regarded as a time when market elements and competitive prices have become an accepted and welcome part of the landscape of the U.S. health care system. Employers have redesigned the health plans offered their employees, introduced utilization review programs, encouraged alternative delivery systems, and adopted various other strategies to obtain a good value for their health care dollar. The federal government has adopted a prospective pricing system for its Medicare population and encouraged states to adopt cost-saving strategies for their Medicaid populations. While those who are insured are likely to be better off as a result of these changes, those who are uninsured will be placed at increased risk of being shut out of the health care system as providers feel more pressure to compete for the paying patient.

These pressures have led to questions about the limits of private insurance and the need for increased governmental programs. There are, to be sure, compelling reasons to expect that more public sector dollars will have to be spent. We need to use public funds to change a Medicaid system that allows some states to set the cutoff level at 25 percent of the poverty line and that excludes many people, no matter how low their income, because of their family or employment status. Other public sector dollars are needed to subsidize risk pools for the uninsurable and to provide places of care of last resort.

The more difficult question is whether our system of private insurance for the employed population can remain voluntary, based on incentives, or whether we will need to impose a mandated system based on regulation. The United States already provides strong incentives to obtain employer-provided insurance by excluding it from employees' taxable income. This system has provided insurance for the vast majority of the working population. Similar incentives could be extended to the self-employed and sole proprietors, and assistance could be offered small

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employers who wish to engage in pooling arrangements.

Some may say that these strategies have already been tried and found wanting, but there are a few instances of communities or employer groups trying creative solutions, either for the large numbers of employed uninsured or for the medically uninsurable. Although the latter represent a very small proportion of the population, problems of adverse selection have been the Achilles' heel of industry pooling arrangements, and the uninsurable risk pools may represent just the safety valve needed for them to work. If these purely incentive-based strategies are found to be insufficient, some form of subsidization could be offered to small employers and/or employers of low-wage workers, either by directly subsidizing the employer or by establishing subsidized risk pools. The problem with this type of subsidization is that many small employers already offer insurance and most low-income workers already have private insurance—and they will want the subsidy. Whether a subsidy can be targeted only to those not now offering insurance is unclear, but some of the demonstrations being funded by The Robert Wood Johnson Foundation may provide the answers. Even if there is some spillover into the currently insured population, it may represent a cost we as a society are willing to bear rather than facing the alternatives. For if these various strategies, coupled with the pressures providers can be expected to bring to the uninsured population, cannot greatly reduce the number of uninsured, the only alternative is mandatory insurance or restructuring the system.

What would be the consequences of a mandatory program of employer-provided health insurance? It obviously depends on whether employers are required to only offer health insurance or are also required to pay a substantial share of the premium. A policy that requires substantial employer contributions has the potential of significantly affecting the employment of low-skilled workers and the competitive position of new and/or small firms. An "offer only" policy—one that allows employers to pay part of the premium but does not require them to do so—should affect neither consumer prices, the firm's competitive position, nor the employment potential of low-skilled workers, and thus should have only minimally adverse effects, if any. Even here, however, Congress will be required to define what qualifies as health insurance, and thus its decisions may affect not only those employers who currently do not offer health insurance but also many employers who already offer insurance. Furthermore, I believe that this type of strategy is not politically possible. If we are willing to mandate the offering of insurance, I think the political pressures to mandate significant employer contributions will be too great to resist.

Perhaps the threat of mandating insurance will be sufficient to push the employer community into greater levels of creativity than it has

exhibited in the past. Even so, some members of the employed population will be left uninsured. We may need to recognize that the price of pluralism is to allow some people (although certainly not 31 million) to slip through the system as long as we make sure that there are places of care of last resort. Or perhaps the threat of mandated insurance will be enough to make a restructuring that includes refundable tax credits to the working population and vouchers for the poor—thus allowing for decentralization, pluralism, and a population of mobile, two-worker families—more politically palatable than it has been in the past.

NOTES

1. G.R. Wilensky, "Solving Uncompensated Hospital Care: Targeting the Indigent and the Uninsured," *Health Affairs* 3 (Winter 1984): 50–62; G.R. Wilensky, testimony before the Subcommittee on Intergovernmental Relations of the Committee on Governmental Affairs, the United States Senate, 16 June 1986; G.R. Wilensky, "Options for Covering Uninsured Workers," *Business and Health* 4 (January 1987): 42–43; see also articles by Uwe E. Reinhardt and Lawrence and Marion Ein Lewin in this issue of *Health Affairs*.
2. Congressional Budget Office, "Profile of Health Care Coverage: The Haves and Have-Nots," background paper, March 1979; and G. Wilensky, D. Walden, and J. Kasper, "Changes in Health Insurance Status: Full Year and Part Year Coverage," Data Preview Number 21, DHHS Pub. no. (PHS)85-3377 (National Center for Health Services Research and Health Care Technology Assessment, National Health Care Expenditure Survey, July 1985).
3. Alicia Munnell, "Insuring Entitlement to Health Care Services," *Bulletin of the New York Academy of Medicine* 62 (January–February 1986); and M.B. Sulvetta and K. Swartz, *The Uninsured and Uncompensated Care: A Chartbook* (Washington, D.C., National Health Policy Forum, George Washington University, June 1986).
4. Unpublished tables.
5. Wilensky, "Solving Uncompensated Hospital Care;" and Sulvetta and Swartz, *The Uninsured and Uncompensated Care*.
6. A.C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, Mass.: Addison-Wesley Publishing Company, 1980).
7. R. Curtis, "The Role of State Governments in Assuring Access to Care," *Inquiry* 23 (Fall 1986).
8. Wilensky, "Solving Uncompensated Hospital Care."
9. William J. Dennis, Jr., "NFIB Small Business Employee Benefits" (NFIB Research and Education Foundation, December 1985).
10. A.C. Monheit, M.M. Hagan, M.L. Berk, and P.J. Farley, "The Employed Uninsured and the Role of Public Policy," *Inquiry* 22 (Winter 1985).

The CHAIRMAN. If the program you described earlier does not work, would you support a mandated system?

Ms. WILENSKY. Yes, if the variety of activities that are going on now do not in fact produce mechanisms to bring in these workers, then I think some form of mandated insurance would be necessary.

The CHAIRMAN. Ms. Davis, you mentioned about the loss of personnel, the potential. Would you perhaps elaborate a little bit on that?

Ms. DAVIS. Logically, if an employer had to pay ten times as much for a worker, say, instead of $8,000, $80,000, they would be able to hire fewer of those workers, so at the extreme you can see how the wage rate has got to affect the number of workers that the employer would hire.

What we are talking about here is something fairly modest, on the order of perhaps 50 cents an hour, so that if you think—there is some evidence, as I say, some of the studies show no effect, others show a small effect—that a 10 percent increase, suppose a 10 percent increase on labor costs led to a 1 percent loss of jobs, we would be talking about maybe having 100,000 jobs affected versus having 24 million people with some type of adequate health insurance coverage. So even that type of tradeoff, even if there were some effect, I think you might well conclude that it is worth it to get that health insurance coverage for those workers.

In terms of the price effect, Dr. Wilensky mentioned that employers, instead of hiring fewer workers, may just pass the cost on to consumers in the form of higher prices, and that is also a possibility, but we have got to think about the other effect, that employers that now are paying for the uncompensated care of the uninsured are passing on to their consumers, in the form of higher prices, the cost for picking up this charity care or bad debt that the hospitals shift onto the privately insured. So you might have an offsetting price effect for those firms that already not only cover the cost of their workers but indirectly are subsidizing the cost of those uninsured who do get care.

With regard to this notion of voluntary efforts, I think it is important to facilitate various types of mechanisms to reduce the costs of health insurance to smaller firms. One of the Robert Wood Johnson projects that Dr. Wilensky mentioned, which is in Boston, would permit workers in Chinese restaurants in the China Town area of Boston to get health insurance coverage as a group, even though they work for different restaurants and they could hold onto their same health insurance coverage. But the employers are not subsidizing that coverage, so the workers have to pick up the full premium themselves, and I think even in that situation, where they can get group insurance more cheaply than individual insurance, you have got to be concerned that those types of minimum wage workers could not afford the premium.

So I think we tried the voluntary approach and what we are seeing is that the situation is getting worse, that we are getting more and more people uninsured, employers are cutting back on health insurance coverage, and the situation is not self-correcting.

The CHAIRMAN. You mentioned lower costs for many businesses that are already providing health insurance coverage. Could you perhaps elaborate on that?

Ms. DAVIS. Again, Dr. Wilensky has done some work on this, but there are estimates that $6 to $8 billion is now being spent on uncompensated care, so hospitals who provide care to the uninsured and cannot collect those bills tend to increase their rates to privately insured patients and then that gets passed to employers in the form of higher premiums, so that is a $6 to $8 billion cost out there that is now being borne by 85 percent of employers that do provide health insurance to their workers. I think this would be a way of redistributing that burden more equitably across all types of employers and could potentially have a job-creating or a price-reducing effect for those firms that already provide that coverage for their workers.

The CHAIRMAN. Dr. Wilensky, do you want to add anything to that?

Ms. WILENSKY. The basic problem that is being addressed here, which is trying to find ways to get the employed uninsured insured, is not anything I have a quarrel with. I am concerned a little more than has been discussed here about the potential employment effects.

I understand, although because of the newness of the release of this bill I have not had a chance to look at it very much, that the current estimates are about 45 or 50 cents an hour. I will be honest to say that since that translates into an insurance package of about $1,200 for a family in total price, I am a little bit dubious as to whether or not that is going to be a sustainable rate, without having much chance to look at it.

If we start talking about, say, 50 cents or more an hour for a minimum wage worker who is now a $3.50 or $3.35 an hour, we are talking about in fact substantially more than the 10 percent raise, as Karen was talking about, and therefore I am truly concerned that there may be some more serious employment effects for the very lowest wage workers.

I would just like to say that while it is hard to know for sure, I do think it is something that we have to give serious consideration for. There is, as we begin to squeeze out of the system, the ability for providers to provide uncompensated care, and I think we are going to continue to do that in the future by putting pressure on these providers. It will reduce some of the uncompensated care, Karen is correct. That ought to reduce some of that pressure on the form of higher prices that was getting passed on to consumers.

The problem with doing this type of a strategy is it is hard to know exactly who pays. That is the problem with shifting costs before. It is a sort of a pin the tail on the donkey, as to who pays, and it is in part some of the problem with doing it this way, is we do not know exactly what will happen to the cost, whether it will get passed on in the form of higher prices or whether it will result in some loss of employment.

Normally, we believe that insurance is incorporated as part of the compensation package. I am trying to suggest, in finding ways to encourage the small employers to offer health insurance who are not doing so, by making it easier and cheaper and with less hassle by these industry pooling mechanisms, is then it would get incorporated into the total compensation package the way it is for all the rest of us, that is, our total compensation is our wage plus our

fringe benefits, and to do it in that way directly is a much cleaner process and that is why I would like to see mechanisms that build on our existing system and only if we are really convinced that that is not going to work, and a lot more creativity than we have shown, then I think we have to consider something more drastic, including mandating.

The CHAIRMAN. The problem is we have had our existing system for some period of time and it has not really responded. I do not think we have been as imaginative as we might be in trying to develop more incentives for small business. I think that is a fair assessment and I think all of us know that it costs them a good deal more and we have not really dealt with some of the problems of smaller businesses.

In terms of the size of unemployment, when we reference the cost of this plan to the minimum wage, if you look over the history of the increases in the minimum wage, they have been significantly more than this plan proposes in percentage terms, and even in the case of these higher increases you have a tough time making the case of an adverse impact on employment. I think I included this analysis as part of my statement earlier, that it is very, very difficult to make the case that unemployment will rise significantly.

In the six or seven times that there has been an increase in the minimum wage, unemployment has actually gone down. The general conclusion of the Commission was that the rate of unemployment was influenced more by other economic conditions than the minimum wage. I am sure we can find those who differ with this conclusion, but we think the weight of the evidence is against them. In looking through those figures and reading through the Commission report, I cannot help but draw the conclusion that in a number of instances where we have raised the minimum wage, the increase has been a good deal higher percentage-wise than what we are talking about here, and you did not have the adverse impact that some thought was going to happen.

Ms. DAVIS. I think the other point that needs to be made is that the minimum wage has basically been cut about 50 percent in real terms, so you are talking about only restoring about 10 percent of what has dropped since 1981, because of inflation.

The CHAIRMAN. OK. I want to thank both of you very, very much. We look forward to working with you on the legislation. Thank you.

[Additional material supplied for the record follows:]

STATEMENT OF
SENATOR LOWELL WEICKER, JR.
MAY 19, 1987

I am pleased to join Senator Kennedy this morning in cosponsoring Minimum Essential Health Care legislation.

The legislation is designed to bring a new era in American health care, one that will be constructed by government and private-sector cooperation, not through expensive or experimental efforts by government alone.

The legislation would require all employers to provide a basic minimum package of health insurance coverage to their employees and the dependents of their employees. The package would include basic hospital and physician care, diagnostic tests, prenatal care, infant care and preventive care for children. Employers would have to pay at least 80 percent of the premiums. Workers' deductibles would be limited to 250 dollars for an individual and 500 dollars for a family. Each employee would not have to pay more than 20 percent of each medical bill or 2,000 dollars of total out-of-pocket expenses.

By requiring that all employers offer a basic minimum package of health insurance coverage to workers and their dependents, this proposal addresses the potentially tragic situation 37 million uninsured Americans face every day in securing decent health care. As the health care market has become more competitive and Medicare and Medicaid have cut back, it has become increasingly difficult for community hospitals to finance the charity care that has traditionally been available to the seriously ill who cannot pay.

At a time when government is engaged in vigorously assuring national security, the security of American health as never been as fragile. Lack of insurance translates to inability to obtain essential care and increased mortality, morbidity and social costs. Last year alone, according to the Robert Wood Johnson Foundation, one million Americans sought health care, but were refused services because they could not pay; more than 13 million did not even seek care they needed because they could not afford it. How can we expect our businesses, indeed our nation, to thrive, if the backbone of our workforce itself is not thriving?

While many Americans already have health insurance coverage and most receive it through the workplace, the largest single group of those uninsured -- a full two-thirds of the 37 million -- are workers and their dependents. This proposal, then, is not a radical one. It simply extends the private insurance system that has served the majority of Americans so well, without extending the federal bureaucracy or regulatory apparatus. Just as employees are guaranteed a minimum wage, participation in the Social Security and Medicaid programs, and unemployment and workman's compensation insurance, so, too, should they be entitled to the protection of health insurance on the job. Because more than half of uninsured Americans have a family member who works more than 35 hours a week, a mandatory coverage law would extend health insurance coverage to a minimum of 20 million Americans.

The businesses that are not providing health insurance to their workers are disproportionately -- but not exclusively -- small. Approximately 48 percent of the uninsured workers are employed by firms of 25 workers or less. Now I realize that small businesses fear they may not be able to absorb the costs of providing health insurance coverage without threatening their own survival. This legislation addresses that very real concern by establishing a structured choice system in each geographic region. Small businesses would be aggregated into larger insurance units to obtain the benefits of community rating, group purchasing power and lower administrative costs. What we have to recognize is that all businesses -- large and small alike -- have a responsibility to shoulder the burden of affording their employees adequate access to health care. The proposal will essentially promote equity among businesses. Under the current system, medical costs uninsured Americans incur are passed on to businesses that do insure their workers in the form of higher hospital charges and insurance premiums.

We owe each and every American access to essential health care. This legislation takes an important first step toward securing that access. Without a commitment to adequate health care, this nation cannot go forward in science or business or education or any other sector of society through which our progress grows.

THE FACTS: MINIMUM ESSENTIAL HEALTH CARE LEGISLATION

--Thirty-seven million Americans, including 12 million children, have no health insurance coverage.

--Approximately two thirds of these uninsured Americans are workers or dependents of workers.

--The Minimum Essential Health Care bill requires all employers to provide a basic minimum package of health insurance coverage to their employees and the dependents of their employees.

--The package will include hospital care, physician care, diagnostic tests, pre-natal care and well-baby care.

--Employers will be required to pay at least 80 percent of the cost of the premium for the package; for very low wage workers, the employer share will be 100 percent. No worker could be excluded from coverage or subjected to pre-existing condition exclusions based on health status.

--The bill establishes maximum co-payments and deductibles and requires that each plan contain a catastrophic stop-loss provision.

--To reduce costs to small employers, the bill establishes a system of coverage options in each geographical region. Small employers would be aggregated into larger insurance units to obtain the benefits of community rating, group purchasing power and lower administrative costs.

--The legislation will reduce costs for the majority of employers who provide health insurance to their workers, because they will no longer be additionally responsible for the cost of charity care provided to workers who should be insured by their own employer.

Remarks of the Honorable
Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives

on the
Minimum Health Benefits for American Workers Act

May 19, 1987

I am pleased to join with my colleague, Senator Kennedy, today in announcing legislation that will at long last assure that nearly every American worker will have health insurance. Senator Kennedy deserves our gratitude for his leadership and dedication in developing this legislation. I look forward to introducing a companion bill in the House of Representatives.

The past forty-odd years has been a time of great improvements in health care coverage. The cornerstone of that expansion has been the private sector providing health insurance related to employment. This approach has been very successful. Collective bargaining agreements and tax incentives have led many employers to offer excellent health insurance packages to their workers.

Unfortunately, many people have been left uncovered even as benefits for most workers have expanded.

We always knew that two large groups would be left out when health insurance was linked to employment -- persons 65 and over, and people unable to work because they had disabilities or were single parents with small children. The Federal government recognized this problem over twenty years ago, and enacted Medicare and Medicaid. Neither program has been perfect, but both have provided millions of people with needed health care.

Now we are increasingly aware that there is a rapidly growing number of other people who have no health insurance -- thirty-seven million by most recent estimates. What comes as an unhappy surprise is how many of these are people with jobs, and their families.

Nearly two out every three people without health insurance are from families where the head of the household is employed.

It turns out that health insurance coverage is to some extent a matter of luck. If you're fortunate enough to work for a large, unionized, manufacturing firm, you're also likely to have good health insurance coverage. But if you work just as hard and have just as many responsibilities, but happen to work for a smaller company you are more likely to have no insurance.

(more)

Being without health insurance is a very serious matter these days. When people without insurance get sick, they get to a doctor and get into a hospital barely half as often as people with insurance. And worst of all, they are more likely to get sick in the first place and then put off seeking care until their illness gets serious.

This situation is intolerable. It is bad health policy and equally bad economic policy. Unless the Congress acts, more and more people will find themselves without adequate health insurance.

The legislation that we are announcing today will go a long way toward correcting these inequities. This legislation builds upon our strong private sector tradition of employment-related insurance.

Nearly all workers will be guaranteed basic health insurance coverage for themselves and their families. Employees and employers will share the costs. The most important preventive services -- prenatal and well-baby care -- will be fully covered. And every worker and family member will be protected against the costs of catastrophic illness.

Even under this proposal, not every American will yet have adequate health insurance. Some people will still have to be incorporated into federally funded programs. Not every needed health service will be provided. We will see what can be done about these limitations as we consider this bill.

This is a modest proposal, perhaps even too modest in some ways, but it is a critically important step for the country to take. Its time has long since come. I ask all Americans to join with us to assure that all workers and their families will finally be confident that they are covered for medical care when they need it.

CLAY TO COSPONSOR WORKERS' HEALTH INSURANCE BILL

Congressman William (Bill) Clay today announced that he will be an original cosponsor of the House companion bill to the Minimum Health Benefits for American Workers Act of 1987, introduced by Senator Ted Kennedy. Joining with Clay in introducing the bill will be Congressmen Henry Waxman, Austin Murphy and Augustus Hawkins.

Clay stated, "We have been working for some time on how to best assure that workers in this country have at least minimum health care insurance. The bill is an important step toward realizing that goal.

"We can no longer afford to ignore the fact that more than thirty five million American workers and their families have no health insurance. Currently, low wage earners without health insurance do not seek treatment until a dire emergency arises. The cost of emergency care is far more than if preventive care had been available. The individual is far worse off, the health costs are much higher, and we all lose. Health insurance coverage helps people stay healthy and also contains costs.

"To their credit, the vast majority of employers do provide health insurance for their employees. But those who provide coverage are placed at a competitive disadvantage by those who don't. In the past under such circumstances, federal labor standards have been created to remove matters of overriding social importance from the uncertainties of the competitive process. Responsible employers should not be penalized for acting responsibly. That is why we are proposing today the creation of a minimum labor standard for health insurance coverage applicable to all employers. Such a policy is consistent with the way in which many important social policy issues have been treated by our labor laws. In the 1930's, we passed legislation prohibiting exploitative wages by requiring the payment of a minimum wage. We passed the Social Security Act requiring employers to contribute to a pension for its employees. More recently, we have enacted OSHA and other labor standards that require every employer to meet a minimum level of responsibility toward their workforce when important social values are at stake.

"These labor standards have a long track record and they have worked. It is time that we treat minimum health care consistently with our notion of a minimum wage," Clay noted.

Clay concluded that, "We plan on beginning the consideration of such legislation in the House at the earliest possible date. I look forward to working with Mr. Hawkins, chairman the Education and Labor Committee, Mr. Murphy and Mr. Waxman, who along with myself chair the subcommittees that have jurisdiction over this issue and who are the original cosponsors of the House companion bill. We intend to move the legislation forward."

MURPHY JOINS MINIMUM HEALTH BENEFITS EFFORT

Congressman Austin J. Murphy (D-PA), today, joined with Senator Edward Kennedy (D-MA), Congressman Bill Clay (D-MO) and Congressman Henry Waxman (D-CA) to introduce legislation mandating minimum health benefits for America's workers.

Murphy cited the growth in the number of uninsured workers, over 19 million in 1985, and the growth of low wage service sector jobs that don't provide these benefits to demonstrate the need for legislation.

"The former steelworkers and former coal miners in my district understand fully the myth of the Reagan Economic Recovery Plan. While jobs have been created, the American economy has shifted employment from manufacturing industries to service industries. American workers have paid the price for a failed trade and economic program in lower wage jobs with no medical security," Murphy explained.

According to Murphy, more than 37 million people in the United States had no public or private health coverage in 1985. Fifty-five percent of those uninsured were employed. Three-quarters of the uninsured workers earn less than $10,000 a year.

Murphy continued, "All American workers are entitled to the very basic protections that health insurance provides. These people, trying to support their families on low wages to begin with, should not be forced to choose between a trip to the doctor or food on the table."

The bill will amend the Fair Labor Standards Act, the Public Health Act and the Employee Retirement Income Security Act to require that employers provide minimum health benefits to employees. The Subcommittee on Labor Standards, which is chaired by Murphy, will have joint jurisdiction over the bill.

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Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey University Hospital
Grady Memorial Hospital (Atlanta)
Santa Clara Valley Medical Center (San Jose)
The Los Angeles County Hospitals
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
City Hospital at Elmhurst (New York City)
Coney Island Hospital
Harlem Hospital Center
Kings County Hospital Center
Lincoln Medical and Mental Health Center
Metropolitan Hospital Center
North Central Bronx Hospital
Queens Hospital Center
Woodhull Medical and Mental Health Center (New York City)
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Center
Nassau County Medical Center
Regional Medical Center at Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center, University of Washington
Fresno County Valley Medical Center
R. E. Thomason General Hospital
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Riverside General Hospital, University Medical Center
Spartanburg General Hospital
Charity Hospital at New Orleans
Maricopa Medical Center (Phoenix)
St. Louis Regional Medical Center
Memorial Medical Center (Savannah, GA)
Amarillo Hospital District
Jackson Memorial Hospital (Miami)
Pontiac General Hospital (Pontiac, MI)
St. Paul-Ramsey Medical Center
E. A. Conway Memorial Hospital (Monroe, LA)
Earl K. Long Memorial Hospital (Baton Rouge)
Huey P. Long Memorial Hospital (Pineville, LA)
Lallie Kemp Charity Hospital (Independence, LA)
Moss Regional Hospital (Lake Charles, LA)
University Medical Center (Lafayette, LA)
Washington-St. Tammany Charity Hospital (Bogalusa, LA)
Tampa General Hospital
Erie County Medical Center (Buffalo)
Prince George's Hospital Center (MD)

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS
1426 TWENTY-FIRST STREET, NORTHWEST ● SUITE TEN ● WASHINGTON, DC 20036 ● (202) 861-0434

May 18, 1987

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
SD-428 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

The purpose of this letter is to express the strong support of the National Association of Public Hospitals (NAPH) for the legislation you are introducing today, which would mandate that employers with 25 or more employees provide a minimum level of basic and catastrophic health insurance benefits.

NAPH is an organization founded in 1981 whose 56 members include over 75 major public hospitals in our nation's metropolitan areas. Quite simply, our member hospitals (together with a handful of other safety net hospitals) currently function, for all practical purposes, as both the financers and providers of care for our nation's indigent and lower income uninsured persons, including those Americans who would be the principal beneficiaries of your proposed measure.

I would like to give you just a few facts about our nation's great public hospitals, in order to put their current role and their support for your bill into a proper perspective:

- <u>The Nation's Public Hospitals and Other Safety Net Institutions Provide Care to a Broad Spectrum of Individuals Identified as Medically Indigent</u>

  Medically indigent patients treated in public hospitals do not fit neatly into a few categories. They include the poor or near poor who, due to state restrictions, do not qualify for Medicaid; the underinsured or inadequately insured; individuals with pre-existing conditions; part-time employees and employees of small businesses; and those suffering from catastrophic conditions.

74-989 - 87 - 5

° Public Hospitals Across the Country Proportionately Provide by Far the Highest Amount of Care to the Medically Indigent

During 1982, urban public hospitals rendered an average of $32,000 in bad debt and charity care per bed, compared with about $7,100 for urban non-profit hospitals. While urban public hospitals represent 5% of the beds in the country, they provided over 40% of the charity care, and over 21% of all uncompensated care (including both bad debt and charity care), nationally in that year.

° Public Hospitals' Indigent Care Load is Increasing -- A Trend Unlikely to Change Without Additional Assistance

Between 1982 and 1984, public hospitals demonstrated a substantial increase in their indigent care commitment; the average NAPH member hospital spent $13 million more in 1984 than in 1982 on care for the medically indigent, an 8.4% increase. Bad debt/charity care represented 25% of these hospitals' average total charges.

The consequences of providing high levels of indigent care remain formidable and potentially crippling. Many public hospitals continue to operate at a deficit. These deficits, on average, five times higher than those of private institutions, are directly related to services provided to low-income patients. The consequences of the safety net role and these deficits include lay-offs, postponed pay increases, and deferred maintenance. At San Francisco General Hospital, The Regional Medical Center at Memphis, and Houston's Harris County Hospital District, privately insured patients have been turned away due to certain inpatient services operating at 100% capacity.

In conclusion, perhaps better than any other group of hospitals in the country, NAPH member hospitals are fully aware that the majority of the increased numbers of lower income, uninsured patients we see in fact are either employed or newly unemployed. A 1982 NAPH survey of unemployed and uninsured patients treated in public hospitals found that 46% of these patients had not used the public hospital before becoming unemployed.

For these reasons, the speedy enactment of the legislation you are introducing today can have a significant impact on both the health status of the individuals it will affect and the ability of our nation's great public hospitals to continue to carry out their mission.

Sincerely,

Larry S. Gage

Larry S. Gage
President

American Nurses' Association
Washington Office

STATEMENT OF THE AMERICAN NURSES' ASSOCIATION

Good Morning. I am Dr. Judith Ryan, Executive Director of the American Nurses' Association, representing over 188,000 of our nation's professional registered nurses. I appear today to address a critical shortcoming in our nation's health care system: the lack of health insurance benefits for millions of working Americans. The ANA is pleased to lend its voice in calling for Congress to provide needed coverage to as many as 37 million employed but uncovered Americans.

We find it unacceptable that many working Americans are not provided health coverage. Our view, regardless of the current political climate, is that health care is a right that must be accorded to all. It is time for the federal government to mandate that employers provide a minimum package of benefits.

As providers of patient care, we know that the cost to our society, both in terms of providing uncompensated care as well as the staggering financial burden on families who must live on fixed wages, is unacceptable. There is no rational reason for providing health care benefits to some workers while not providing them to others. Moreover, we are all indirectly paying for the care of those who are uninsured through the tax code. It is time to instill a degree of equity in this area.

American Nurses' Association
Washington Office 1101 14th Street, N.W. Suite 200 Washington, D.C. 20005 (202) 789-1800
ANA – An Equal Opportunity Employer

While health care in our nation is regrettably not yet a right of citizenship, the ANA is hopeful that proposals like Senator Kennedy's will offer some assurance that all working Americans will be guaranteed a minimum package of benefits that will provide essential health care services. Individuals should also have access to the health practitioner of their choice. The ANA looks forward to working with Senator Kennedy to ensure that our greatest national resource, working people, is provided the most basic right - health care.

STATEMENT OF

MICHAEL D. BROMBERG

EXECUTIVE DIRECTOR

FEDERATION OF AMERICAN HEALTH SYSTEMS

BEFORE THE

SENATE COMMITTEE ON

LABOR AND HUMAN RESOURCES

ON

ACCESS TO HEALTH CARE

MAY 19, 1987

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The Federation of American Health Systems is the national association of investor-owned hospitals and health care systems representing over 1,400 hospitals with over 172,000 beds. Our member management companies also manage under contract more than 350 hospitals owned by others. In many communities, investor-owned facilities represent the only hospital serving the population.

The Federation of American Health Systems recognizes that of the many issues confronting our nation, few are more pressing than the need for a comprehensive solution to the growing problem of uncompensated care. Federal and local support programs are inadequate to provide health care for the increasing numbers of those who are poor or underinsured.

The Federation of American Health Systems believes it should be a national priority to develop an effective public policy to finance and deliver health services to those who are unable to pay for their health care and who are uncovered by existing government or adequate private insurance programs. This issue is increasing in importance as the health system becomes more price competitive due to pressures from business, insurers and government to reduce costs.

More than 17 percent of the under age 65 population lacks government or employer sponsored health care insurance. Histor-

ically, services to indigent patients have been subsidized by private patients as part of charges or have been provided at public hospitals where part of the operating funds were funded from state and local taxes.

Our health care delivery system has undergone a revolution. The revolution, moving from a cost based to a price based system has caused a change almost overnight in the way hospitals do business. Purchasers of health care also play a significant role in this revolution by now demanding more cost effective and efficient care.

Price competition has made it difficult for private hospitals to continue cross-subsidizing indigent care. Private payers, employers and business coalitions have mounted increasing resistance to paying for uncompensated care through this cross-subsidy. Uncompensated care provided by hospitals doubled between 1980 - 1984 - to $5.7 billion. The total uncompensated care burden on private community hospitals now exceeds $6.3 billion. The investor-owned sector of the hospital industry assumes over $690 million of that total, representing over 4.3 percent of their revenues, approximately the same percentage as non-profit, non-public hospitals. The amount of uncompensated care provided by our tax-paying hospitals has risen at a rate of over 16 percent during the last several years.

Data indicates that of the 35 million persons under 65 who are uninsured, 54 percent are steadily employed and another 17 percent are employed for part of the year. Thus by addressing coverage of this population, Congress could achieve enormous progress towards solving the critical problem of uncompensated care.

The Federation of American Health Systems member companies and hospitals employ over 500,000 persons. Federally mandated health benefits will increase the cost of doing business for many of our members. However our Board voted unanimously to endorse the concept of mandating health benefits for the working uninsured and their dependents. The health care industry is labor intensive, thus our industry understands the importance of and depends on the health of our employees to deliver quality health care to our patients.

The Federation believes all employers should provide basic protection against the costs of health care for their employees. This protection should meet minimum federal standards. In order to balance the goal of assuring health protection to employees without jeopardizing the availability of jobs, it is important to design a benefit package which is minimum and to establish a fair formula for sharing premiums between employers and employees.

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Employers should be encouraged to offer multiple health plans, including a low cost option. Employers should pay at least two-thirds of premiums for a minimum benefit package designed to keep premiums affordable for both employers and employees. We also support the use of reasonable copayments and deductibles as a way to encourage the more efficient utilization of health care services and an opportunity to develop a flexible benefit package more suited to the particular needs of individual consumers.

Small employers must be assisted in securing affordable coverage for their employees. We must assure their access to similar group rates enjoyed by larger employers through multiple-employer group plans in which employers join together to secure lower rates. It may prove advantageous not to limit assistance to only very small employers of 25 workers or less, but to expand provisions aiding small employers to include those employing a significantly greater number. Helping small employers join together to form multiple employer units for purposes of obtaining health insurance will help spread the risk among a larger population. Access to these larger groups and help with administration of plans, a large component of insurance expenses, will lower the costs for both the employer and the insurers providing coverage. For example, state and/or private organizations could create the necessary administrative apparatus to:

- o give small employers a central, easy-to-reach source for finding out what kinds of coverages are available at what price;

- o help small employers join together to form multiple employer units for purposes of obtaining health insurance; and

- o give small employers access to the buying expertise of professional benefits managers from large companies.

There are several significant advantages to using employer-based coverage as a solution to the problem of access to health care. As stated previously, by mandating employer based health insurance coverage, the majority of the uninsured population will receive benefits. This approach will result in fewer people without health insurance coverage, and lessen the need for large, subsidized risk pools for the uninsured.

Less cost shifting will occur for employers, who by providing ample coverage to their employees, also indirectly subsidize the employed but uninsured. This will place companies in a particular industry on equal footing, in that fewer companies can gain an inappropriate competitive advantage by denying their employees health insurance.

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Critics of mandatory employer-based health benefits argue that it will increase costs to small employers and may therefore reduce employment. However, in many cases, costs can be passed on through pricing of goods and services to customers, with no one competitor disadvantaged relative to the other. Also, mechanisms to help small employers access lower group rates and to alleviate their administrative costs, will meet this objection.

Furthermore, some companies already providing health benefits for their employees, once relieved of the burden of paying for those not insured, may experience lower costs.

As far as the issue of U.S. companies being less competitive in world markets because of mandated coverage, most of the employers not providing coverage now are in the service sector, where foreign competition is not a significant factor. As our economy becomes more service oriented and less industrialized, it is particularly important to assure employees protection against catastrophic illness.

Senator Kennedy, your recommended coverage for prenatal, well-baby and preventive care for children in the "Minimum Essential Health Care Law," is to be commended for several reasons:

o Significant long term savings can be achieved by pro-

viding these preventive health care services.

- Infant mortality statistics, a subject of much concern for our country, may improve as a result of insuring such care; and

- A significant portion of indigent care in hospitals, over 40%, is for maternal and child health care.

We believe coverage of mental health services should be treated as other medical services both on an inpatient and outpatient basis. At the very least these services should be covered when a beneficiary has reached the out of pocket stop/loss limit. According to a major study sponsored by the National Institute of Mental Health (NIMH), at any given time about 29 million Americans - 19% of the population over age 18 - suffer from psychiatric disorders. We cannot overlook the critical health care needs of this population.

Mr. Chairman, the Federation commends you for your leadership on the access issue and endorses the general approach outlined in the "Minimum Essential Health Care Law," because it would greatly alleviate the critical indigent care problem facing our nation's health care providers. However, it would be wrong to believe that employer based insurance alone will solve the access problem.

While you have proposed a budget neutral plan consistent with the legislation of this Gramm-Rudman era, we hope you will continue to urge a reordering of national priorities, including a recognition that unemployed medically indigent patients are the responsibility of all society.

The Medicaid program must be restructured with a federally established poverty standard mandated for all states. This would result in the upgrading of state Medicaid programs to reasonable eligibility standards for benefits.

Senator Chafee's recently introduced bill, S. 1139 the "Med America Act of 1987," provides to states the option of providing Medicaid benefits to anyone whose income is below the federal poverty level regardless of whether or not they qualify for cash welfare programs. It would also allow the working poor to purchase health insurance through Medicaid for an income adjusted premium. Finally, it would allow the "uninsurable" to purchase Medicaid benefits. Improvements to the Medicaid program, such as those recommended by Senator Chafee, will ease the burden of uncompensated care for both beneficiaries and providers of health care, by improving access to health care services.

Even if minimum health benefits are mandated for all employ-

ers, there will remain a substantial population of the unemployed uninsured and underinsured who are unprotected. The public financing of their health care cannot be ignored.

The basic public policy question is whose responsibility is it to finance this needed care? We believe government has a proper role as provider of last resort for the poor. The public hospital has historically filled that role as an arm of government, but adequate funding is not being appropriated and more efficient delivery of care must be assured. The tax revenue to finance indigent care should be broadly based because society as a whole should meet its responsibility to care for the disadvantaged.

We have relatively good data on the amount of uncompensated care but we do not have accurate data or reliable estimates of how much health care is not being sought because of inability to pay. The fact is that both mandated employer insurance and more equitable public programs for the medically indigent may increase health expenditures as a percentage of our gross national product. As long as that increased health care is needed by those unable to pay for it, society has an obligation to assure that financing through government as payer of last resort.

In conclusion, we strongly support the current evolution of the health care system towards competition based on price and quality. However, to foster this environment we must make solving the indigent care problem a national priority. We support the concept of employer provided minimum health insurance protection for all employees coupled with broadly based public financing of health care for the unemployed poor in our nation.

STATEMENT OF THE

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Presented by

ROBERT GRAHAM, M.D.

Executive Vice President

On

MINIMUM HEALTH BENEFITS FOR AMERICAN WORKERS ACT

OF 1987

May 19, 1987

It is a pleasure to be with you here this morning to recognize the important initiative Senator Kennedy has taken to improve access to needed health care services through the introduction of the Minimum Health Benefits for American Workers Act of 1987.

The American Academy of Family Physicians, as the voice of America's family doctors recognizes well the devastating impact lack of availability of health services can have on individuals and their families. We believe (as suggested by the 1983 report of the Presidents Commission on Biomedical Ethics) that every American should have access to an appropriate level of health services...and one of our commitments a as health care organization is to work towards this end.

We are in an era where the debate regarding expansion of health services tends to be dominated by concerns regarding costs. And the concern regarding costs is perceived as being an absolute barrier to increasing access.

However, recent evidence suggests that inadequate access to services may actually increase total costs in the health care system, and shift the burden of final payment inappropriately. This cost shifting may be to a later time, a more serious condition, or an alternative payor. Relatively innocent conditions, such as a strep throat, left untreated may progress to more serious and costly conditions, such as chronic or end stage renal disease.

We believe that Senator Kennedy's bill provides a useful starting point to debate these issues. We applaud his intent to expand availability of insurance coverage to a large population of Americans presently without it, and we support his approach of providing such an increase in enfranchisement through private sector coverage.

Of course, we, as do others, have concerns regarding some of the provisions as drafted. The present proposal, although mandating preventive and health maintenance care for children, has no similar provision for adults. This is a serious omission. Similarly, the structure of the economic impact on small businesses will require close attention. We will look forward to the opportunity to work with Senator Kennedy and other members of the Committee on Labor and Human Resources to address these issues as the bill progresses through subsequent drafts.

These issues are complex, but the needs are compelling. We believe that, in the long run, improved access will lead to reduced costs, and a better quality of life for our citizens. The initiative taken today may, if properly conceived and implemented, move us further along the road to those important goals.

STATEMENT OF ROBERT M. BRANDON
WASHINGTON DIRECTOR, CITIZEN ACTION
May 19, 1987

I am happy to be here today to announce Citizen Action's strong support for the Minimum Essential Health Care Act of 1987. Citizen Action is a cooperative federation of 25 statewide organizations with a national membership of over 1.5 million persons.

There is a desperate need for the protections provided in this landmark legislation: the guarantee of employer-provided health benefits to workers. In 1985, nearly one out of every five persons under 65 in our nation had no health insurance of any kind. More than three-quarters of the 37 million uninsured were workers and their families. This bill will not solve all the problems connected with our nation's health care crisis. But it will provide a basic level of guaranteed care to nearly 30 million men, women and children. And it will ensure that American workers -- the foundation of our economic prosperity -- will be healthy and productive.

Statistics alone do not tell the story. Citizen Action, through its canvass, talks with 5 million households each year. In household after household, we hear the pleas for help from working women and men unable to afford health care for their children. We hear from people who put off going to doctors for care until their health care needs become too critical to ignore. We hear from mothers and fathers wanting to go to work but knowing that once they become employed they will lose critical Medicaid coverage. We hear from currently-covered workers who are afraid that their employers will cut back on coverage or raise deductibles and copayments to unaffordable levels. And we hear from workers who cannot afford to transfer to new jobs because doing so would cost them health coverage.

Because of our firsthand experience with the crises faced by all those people, Citizen Action is making passage of MEHCA a top priority. We will go door-to-door to channel public support for it, through a petition drive designed to collect 1 million signatures by the fall. Together, we will show that Americans care about filling the holes in our tattered health care system and are willing to take whatever steps are necessary to provide decent health care for all.

Fact Sheet on Citizen Action and Health Care

Campaign California
Citizens Action Coalition of Indiana
Colorado Citizen Action Network
Connecticut Citizen Action Group
Florida Consumers Federation
Idaho Fair Share
Illinois Public Action Council
Iowa Citizen Action Network
Maryland Citizen Action Coalition
Massachusetts Fair Share
Maine Peoples Alliance
Minnesota COACT
Missouri Citizen Labor Coalition
New Hampshire Peoples Alliance
New Jersey Citizen Action
New York Community Action Network
Ohio Public Interest Campaign
Oregon Fair Share
Pennsylvania Public Interest Coalition
Rhode Island Community Labor Coalition
Virginia Action
Washington Fair Share
West Virginia Citizen Action Group
Wisconsin Action Coalition

The Nation's Largest Progressive Grassroots Organization:

Founded in 1979, Citizen Action has 1.5 million members, 25 state affiliates and allied organizations, 75 offices, 1,200 staff, and a combined budget of more than $20 million. Citizen Action's affiliates and allied organizations are in 25 states: California, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Virginia, Washington, West Virginia, and Wisconsin.

Public Education Efforts:

Citizen Action's canvassers speak to 20,000 families a night -- and over five million households a year -- as part of an effort to build membership, educate the public on issues, win legislative victories, and, during the campaign season, elect progressive candidates.

National and State Legislative Focus:

On the national level, Citizen Action played a key role in the successful fight for an expanded Superfund, in opposing gas decontrol, and in launching the National Health Care Campaign for affordable, accessible and high quality medical care.

At the state level, Citizen Action has helped win major victories on health care, such as: expansion of Medicaid (six states); prescription drug assistance programs for senior citizens (four states); mandatory Medicare Assignment (two states); establishment of state People's Health Advocacy Offices (two states) and home health care (one state). Other state legislative successes include no shut-off policies for utilities (18 states) and community right-to-know laws disclosing toxic hazards (ten states).

Health Care -- A Key Issue for Citizen Action in the 1980's:

Citizen Action helped put together and provides support for the National Health Care Campaign, contributing grassroots organizing assistance in the field, and research, policy development and legislative strategy support in Washington. Efforts are focused on building health care coalitions in 25 states, and developing comprehensive legislative programs at the state and national level to make quality health care more affordable and accessible. The Minimum Essential Health Care Act is a top priority for Citizen Action.

Other Issues:

In addition to health care, Citizen Action is working to achieve solutions on many other key issues of the 1980's: protecting communities against toxic wastes, grappling with corporate merger-mania and the decline in jobs with adequate wages and benefits, increasing democracy through changes in voter registration and campaign finance laws, strengthening Medicare and Social Security, controlling energy prices and utility rates, and addressing the plight of families, the poor, and family farmers.

Statement by John J. Sweeney, President
Service Employees International Union

The health cost crisis of the early 80's has not gone away, but it has spawned the health coverage crisis of 1987.

The stark reality is that today Americans are losing their health insurance.

More than 37 million people --- one in six --- now have no health coverage. An increase of 50 percent in six years.

In 1986, more than 12 percent of all Americans --- nearly 14 million people --- needed medical care but had difficulty getting it.

Until the late 70's our society seemed to be making steady progress toward the goal of decent, affordable health care to all of us --- primarily through employment based health insurance.

But our economy is undergoing dramatic change and employee health care is being lost in the transition.

Economic trends point to an eroding manufacturing base, where most employees have health insurance, and a switch to a service economy, where coverage is harder to come by.

Sixty-five percent of uninsured Americans are workers or their dependents, and sixty percent of employees without insurance work in service jobs.

Three quarters of them make less than $10,000 a year.

And a recent study shows that three out of every five new jobs created since 1980 pay under $7,000.

Two of the workers who will testify this morning are members of my union. Unfortunately, they are typical of service workers --- members of the "new economy" we read so much about. The earn slightly more than the minimum wage and enjoy few, if any, benefits.

For instance, there is no health insurance offered by their employer, despite aggressive bargining by their local unions to secure coverage.

Among industrialized nations, we alone have no program of national health care. And establishing universal health coverage is a long-standing goal of the american labor movement.

As president of the 850,000-member Service Employees International Union, and chairman of the AFL-CIO's Healthcare Committee, I speak today for sweeping action to hold back the tide that threatens to leave millions of workers and their families with no health protection.

I strongly urge congress to pass the bill introduced by Senator Kennedy.

It takes the historic step of requiring all employers to provide basic health protection --- something more and more employers fail to do on their own.

It's not different from other minimum standards of employment determined by statute --- like unemployment insurance, the minimum wage, and social security.

This bill promises relief for low-wage wage earners, part-time workers and taxpayers, who have had to pick up the tab for businesses --- large and small --- content to pass the buck for providing health coverage to their employees.

Senator Kennedy does not intend to drive small business into bankruptcy.

To the contrary, this bill promises lower costs to business who currently can't afford the prohibitive health premiums, by pooling the contributions of many small employers.

And the bill preempts state-required minimum benefits, to lessen the burdens on both employers and insurance carriers.

Senator Kennedy's bill is a crucial first step in developing a national program to protect all our citizens from the tragedy that lack of health insurance brings.

It deserves our support.

HEALTH CARE NEWS

NATIONAL HEALTH CARE CAMPAIGN
P.O. Box 27434
Washington, D.C. 20038
(202) 639-8832

For Immediate Release
Contact: Bruce Fried
202-639-8833

Statement of the
National Health Care Campaign

Three-quarters of the 37 million Americans without health insurance of any kind are workers and their families. They, like the rest of the uninsured, face potential personal tragedies because of their inability to pay for basic medical care, especially preventive services which are so important in avoiding costly serious illness. To solve the growing crisis of the uninsured, the National Health Care Campaign--comprised of national senior citizen, child advocacy, labor, religious, citizen action and disability organizations and 27 state coalitions--has called on Congress to enact legislation to:

-- Require employers to provide adequate health insurance for workers and their dependents
-- Expand Medicare coverage to include prescription drugs and long-term care
-- Cover all who live in poverty under the Medicaid program
-- Assure access to health care for Americans who have no insurance due to cost or health status.

The following members of the National Health Care Campaign, therefore, applaud Senator Edward M. Kennedy and Representatives Henry Waxman, William Clay, and Austin Murphy for putting the health care crisis on the national agenda.. The Minimum Essential Health Care Act would guarantee provision of a minimum package of health care benefits for workers and their families, providing access to medical care to the majority of the now-uninsured. Introduction of this bill is a critical step in the creation of a national policy that guarantees comprehensive health care to all.

American Council of the Blind
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Public Health Association
Center for Law and Social Policy
Church Women United
Citizen Action
Communications Workers of America, AFL-CIO
Congress of National Black Churches
Consumer Commission on the Accreditation of Health Services

(more)

Consumer Federation of America
Consumers Union
International Association of Psychosocial Rehabilitation Services
Lutheran Office for Governmental Affairs
National Association of Community Health Centers
National Association of Social Workers
National Citizens Coalition for Nursing Home Reform
The National Council on the Aging
National Consumers League
National Council of Senior Citizens
National Education Association
National Foundation for Ileitis and Colitis
National Organizations for Rare Disorders
National Rainbow Coalition
Newspaper Guild, AFL-CIO
Older Women's League
Service Employees International Union
Southern Christian Leadership Conference
United Electrical, Radio, and Machine Workers of America (UE)
United States Student Association
Villers Advocacy Associates
Womens Equity Action League

NEWS FROM THE UAW

FOR RELEASE: Immediate, Wednesday, May 20, 1987

UAW ENDORSES PROPOSAL FOR GREATLY EXPANDED HEALTH CARE COVERAGE

UAW President Owen Bieber today issued the following statement in support of the proposed Minimum Health Benefits for American Workers Act of 1987:

The UAW applauds Senator Kennedy and Representatives Clay, Murphy and Waxman for their leadership in addressing one of the most serious social problems facing this country, the lack of health insurance coverage for millions of working Americans and their families. Today some 35 million Americans lack health insurance coverage. The vast majority of the uninsured are working men and women and their dependents. The failure of many employers to provide their workers with even a minimum level of health benefits means that millions of Americans do not have access to needed health care services. It also means that the health care costs which are incurred by the uninsured are unfairly shifted either onto the government or onto other employers who do maintain health care plans.

The legislation which is being introduced today by Senator Kennedy and Representatives Clay, Murphy and Waxman -- the proposed "Minimum Health Benefits for American Workers Act of 1987" -- would address both of these problems. It would assure that all American workers and their families have access to health care by requiring employers to provide at least a minimum level of basic health insurance benefits for all of their employees and eligible dependents. And it would greatly reduce the shifting of health care costs onto the government or other employers by requiring all employers to pay their fair share for these health insurance benefits.

UAW
INTERNATIONAL UNION,
UNITED AUTOMOBILE,
AEROSPACE AND
AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA

PUBLIC RELATIONS
AND PUBLICATIONS
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The approach adopted by this legislation -- requiring employers to meet certain basic standards as a condition of doing business -- reflects a characteristic American approach to solving social problems. It is consistent with legislation previously enacted by Congress requiring employers to provide a minimum wage and to meet certain minimum health and safety and pension standards.

The UAW recognzes that many important aspects of this legislation must be reviewed and refined. For example, although we are pleased that the bill protects low-wage workers by requiring employers to pay 100% of their health insurance premiums, we believe that this requirement should be expanded to apply to all workers. The UAW looks forward to working with the sponsors of the bill on this and other matters as it moves forward in the legislative process.

Ultimately, the health care needs of all Americans can only be met by a universal and comprehensive national health insurance program. However, the legislation being introduced today by Senator Kennedy and Representatives Clay, Murphy and Waxman would take a major step forward by assuring a minimum level of health care benefits to the vast majority of those individuals who currently lack health insurance coverage. We therefore urge Congress to give prompt, favorable consideration to this important legislation.

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A P
H A NEWS RELEASE

AMERICAN PROTESTANT HEALTH ASSOCIATION SUITE 311/ONE WOODFIELD PLACE/1701 EAST WOODFIELD ROAD
SCHAUMBURG, ILLINOIS 60195-5108/TELEPHONE (312) 843-2701

THE AMERICAN PROTESTANT HEALTH ASSOCIATION SUPPORTS SENATOR KENNEDY'S LEGISLATION FOR MANDATORY EMPLOYEE HEALTH INSURANCE

Washington, D.C., May 19, 1987. Charles D. Phillips, Ed.D., today announced the support of the American Protestant Health Association, an organization representing over 300 church affiliated hospitals and related health care facilities, for legislation being introduced by Senator Edward M. Kennedy (D-MA) to require employers to provide a minimum health insurance package to employees and their dependents.

Participating in a press conference to announce the legislation, Dr. Phillips, President of APHA, said, "In our hospitals, we see on a daily basis the consequences and hardships experienced by employed individuals and their families who currently have no insurance coverage. Having no insurance means that people, including children, put off essential health care until a serious health problem has developed, and then, with the uncertainties as to how they can afford health care, they seek our help, oftentimes in emergency situations. As an organization of church affiliated health care facilities, we are committed to serving all who seek our help, regardless of ability to pay. But with private insurers and the federal government clamping down ever and ever more tightly on reimbursement, and with 37 million people lacking even the most basic insurance, our resources and ability to keep our doors open are increasingly stretched to the breaking point. There is simply no reason why this Nation, committed as it is to justice and equality, cannot assure a minimum level of health care for working Americans and their families. We congratulate Senator Kennedy on proposing this legislation and indicate our intention to work with the Senator and other key Members of Congress to formulate a fair and workable solution to this health care crisis."

Contact: Charles D. Phillips
(312) 843-2701
Frederick H. Graefe
(202) 857-2215

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NEWS FROM NAM

87-116

FOR IMMEDIATE RELEASE

LAURA BROWN CLEARY (202) 637-3087
SHARON CANNER (202) 637-3124

N.A.M. OPPOSES KENNEDY'S MANDATED HEALTH BENEFITS BILL,
SENDS STRONG MESSAGE TO CONGRESS

WASHINGTON, DC, May 18, 1987 -- The National Association of Manufacturers sent a strong message to Congress today opposing Sen. Kennedy's new bill to require all employers to provide health benefits to workers and their dependents.

"Enactment of this legislation would disrupt existing employer health plans, significantly increase corporate health costs, and diminish industry's competitive position," said Alexander B. Trowbridge, president of the 13,500 member association.

"The availability of health care for the poor and uninsured is a broad-based problem, demanding a variety of creative, thoughtful and fiscally responsible approaches," he continued. "But the 'uninsured' as defined in this bill run the gamut from the truly needy to college students with part-time jobs. A single legislated mandate is not appropriate to such a complex pattern of coverage."

Urging Congress to "spread the costs over the broadest possible base," Trowbridge listed a number of workable alternatives to expand healthcare coverage, including state programs for the uninsured financed by general revenues, tax incentives for the self-employed to offer health benefits to their workers, and a Medicaid buy-in for those whose income exceeds federal standards but who cannot afford to

purchase insurance.

"The N.A.M. has urged member companies to extend coverage when and where it is practical and appropriate, and to support development of mechanisms for cost-effective group health coverage for small firms," he added.

"Federal mandates which ignore realities in the business community, stifle economic expansion and could lead to actual job loss are not the answer. The Kennedy minimum health plan, while well-intentioned, would adversely affect many employer plans which are making affordable health care available to workers and their families. In 1985 alone, employers paid out $105 billion in health care benefits, and an additional $22 billion for their share of Medicare payroll taxes. In seeking ways to expand health care coverage, let's not hit hard on companies which already are doing everything they can to provide benefits and stay competitive.

"While characterized as a minimum benefits plan, the Kennedy proposal appears to require design changes in almost all current employer plans, many of which are by no stretch of the imaginination 'minimum.' The bill also adds another cumbersome layer to the federal bureaucracy, even though recent regulations under the COBRA legislation have not yet been implemented -- and their impact on business is not yet known.

"It is ironic, and disturbing, that as Congress focuses on ways to make U.S. businesses more competitive in the world marketplace, we find this and other proposals to load massive new costs on industry," he concluded.

-N.A.M.-

The CHAIRMAN. The Committee is adjourned.
[Whereupon, at 11:37 a.m., the Committee was adjourned.]

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